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ABSTRACT

This hearing transcript presents statements and testimony regarding effectiveness of the Healthy Start Demonstration Project to reduce U.S. infant mortality rates and authorization for funding to establish new sites and to enable exiting programs to act as mentors for and to disseminate information to new projects. Opening statements are presented for Senators Nancy Kassebaum, Chair of the Committee on Labor and Human Resources, and Massachusetts Senator Edward Kennedy. Prepared statements are then presented for Pennsylvania Senator Arlen Specter, and Dr. Louis Sullivan, former secretary of the U.S. Department of Health and Human Services, and creator of the Healthy Start initiative. These statements explore infant mortality rates and highlight the effectiveness of the projects in terms of prevention and the need for continued funding. Testimony is then presented from administrators of Healthy Start sites and recipients of these program services, as well as from Marie McCormick, Chair of the Department of Maternal and Child Health at the Harvard School of Public Health. Prepared statements from the president of a Healthy Start site describing the Healthy Start Initiative in Boston, and from the March of Dimes Birth Defects Foundation supporting continued funding and highlighting March of Dimes' involvement with Healthy Start conclude the transcripts. Correspondence to Senator Kassebaum regarding Healthy Start is included. (HTH)

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OVERSIGHT OF THE HEALTHY START DEMONSTRATION PROJECT

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HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

ON

THE IMPLEMENTATION OF THE HEALTHY START DEMONTRATION PROJECT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, CREATED TO REDUCE INFANT MORTALITY, AND ITS PROPOSED AUTHORIZATION FOR FISCAL YEAR 997

MAY 16, 1996

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OVERSIGHT Of THE "HEALTHY START" DEMONSTRATION PROJECT

THURSDAY, MAY 16, 1996

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:40 a.m., in room SD–430, Dirksen Senate Office Building, Senator Kassebaum (chairman of the committee) presiding.

Present: Senators Kassebaum, Gorton, Faircloth, and Kennedy.

OPENING STATEMENT OF SENATOR KASSEBAUM

The CHAIRMAN. This morning's hearing will please come to order. This is an oversight hearing on the Healthy Start demonstration project, at the request of our first witness, Senator Specter. As chairman of the subcommittee on Appropriations, Senator Specter has supported this effort and has a keen interest in it. So it is a pleasure to be able to have this hearing this morning in order to take a look at the Healthy Start project and review it.

It is a 5-year demonstration project that received its first appropriation in 1991. The program was created by Dr. Louis Sullivan, who is here this morning, when he served as Secretary of Health and Human Services in the Bush administration.

The primary purpose of the program is to reduce infant mortality, focusing on geographic regions with infant mortality rates 150 percent above the national average. The objective of Healthy Start was to cut in half the infant mortality rates in those regions, which stood at 10.1 percent at the time of the program's inception.

There are 22 program sites across the United States. Although the demonstration grants are to end in 1996, President Clinton has recommended $75 million in appropriations for Healthy Start in fiscal year 1997.

The purpose for the continuation of funds is to establish new sites and to enable existing programs to act as mentors for and to disseminate information to new projects.

My hope this morning is that the witnesses will be able to give members of the committee an overview of the program and its performance and perhaps recommendations for ways that it can be improved. I appreciate everyone's participation in the hearing this morning.

Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Thank you very much, Madam Chairman. I want to thank you very much for having this hearing and Senator Specter for bringing this important program before the committee. I also want to extend a warm welcome to Dr. Sullivan, who is an old personal friend and has also been a great friend to this committee over his many years of distinguished service.

I think all of us are very much aware, Madam Chair, of where we are in terms of infant mortality compared with the other countries of the world and, even more dramatically, what we are seeing in our own communities across the country. We are certainly encouraged by the Healthy Start proposal, which gives some targeted funding, to bring focus on the challenges of infant mortality.

So many of the profiles of communities across the country that are being served by Healthy Start show many similarities to the larger Medicaid population. We are talking about the same families in both cases.

Healthy Start is a valuable program, but in order for it to be most effective, I believe it must be accompanied by other health and social services. This is common sense; it is what the people working in the Healthy Start program say.

Even as we are here this morning, we are facing over on the Senate floor significant proposals for reductions of some $72 billion from the Medicaid program over the next 6 years. That large a cut will dismantle the safety net these families rely on for their children.

Providing a healthy start means incorporating immunizations, and in broader terms, it also means the essential screening and development tests that are available to identify and treat childhood diseases, and it means that decent nutrition will be available. Unless these services are provided, I think we are not really meeting the Nation's and our families' responsibilities to our children, because children's needs do not stop at birth or at 30 days or at 6 months or on their first birthday. If we are serious about keeping children healthy and strong, we cannot abandon them after that.

So the Healthy Start program is a good one, but it is not enough to get the job done. It is in this context that we are giving focus and attention to this program. I personally was very impressed that, during the debate and discussion that we had on the broader health care legislation a few years ago, we had broad bipartisan support for more comprehensive health care for all children from both Republicans and Democrats. There was a very strong endorsement for this concept.

I would hope that after we have the achievement of the Kassebaum-Kennedy bill, which deals with some of the challenges of preexisting conditions and job lock; which will make a great deal of difference to millions of our fellow Americans, that we will look at the needs of children as perhaps our next order of business.

I want to thank Senator Specter for his constancy in terms of the support that he has given children's needs in the Appropriations Committee. We are glad to join in welcoming him here today.

The CHAIRMAN. Thank you, Senator Kennedy.

It is a pleasure to welcome the senior Senator from Pennsylvania and our colleague, Senator Specter.

STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Thank you very much, Madam Chairwoman, and good morning to Senator Kennedy and you.

When you talk about senior Senators, I will soon be congratulating you for being the senior Senator from Kansas.

The CHAIRMAN. Briefly.

Senator SPECTER. But nonetheless. I see the picture on the front page of The Washington Post today of those who surrounded Senator Dole yesterday, and I know that you were in that group. I saw Senator Bennett, but I did not see you, Senator Kassebaum; it may be because he is a foot and a half taller, but he was visible in the picture, and you were not.

I thank the committee for scheduling this hearing today, and at the outset I commend you, Senator Kassebaum, and you, Senator Kennedy, for your leadership, especially on the Kassebaum-Kennedy bill, and for all the other things you have done over the years.

This program, Healthy Start, I think has had enormous success with a relatively small amount of money. I appreciated the scheduling of this hearing following our discussion on the floor, when I thought we might provide for an authorization of the Kassebaum-Kennedy bill, but fully understood the reasons why the sponsors wanted to keep it a clean bill.

My staff and I are in the process of preparing legislation, which is not yet finished, for drafting for authorization. We are looking for an authorization, thinking of $100 million a year, and by the time we put it into final form, it may be more than that.

My special interest in this program arose in 1984, when I visited the Alma Ellory Clinic in Pittsburgh, PA and was astounded to learn that Pittsburgh had the highest infant mortality rate of any city in the country, which astounded me considering the medical facilities available in Pittsburgh. And when I saw my first one-pound baby, I was really astounded to see this human being no bigger than the size of a person's hand; some weigh as little as 12 ounces. After that, I visited many hospitals to take a look at the low birth weight babies and have really been astounded to see babies coming into this world weighing that little, with the scars they carry for a lifetime. They are enormous expenses—up to as much as $500,000 per individual and tremendous costs during the course of their lifetimes.

I know that this committee and my subcommittee and the Department of Health and Human Services have been working hard to find ways to cut those costs.

I would ask unanimous consent that my full statement be included in the record, and I will summarize just briefly some of the highlights.

The CHAIRMAN. Without objection, it will be so included.

Senator SPECTER. As already noted, the formal Healthy Start program was begun under the distinguished leadership of Dr. Louis Sullivan, the Secretary of Health and Human Services. The statistics are really astounding, with the United States ranking 22nd

among industrialized nations, with a death rate of 8.5 deaths per 1,000 births in 1992. We have appended the mortality rates of major cities across the country to give an idea as to what is happening in all the States, like Kansas, like Massachusetts.

We know that all politics is local. When we take a look at what is going on in Wichita and in Boston and in Worcester, the statistics are just totally unacceptable—Boston, 10.2, which is higher than the national average; Wichita, 10.8, also higher than the national average.

Low birth weight babies are 40 times more likely to die in their first month of life. Sixteen percent of all costs for initial hospitalization and special services up to the age of 35 are attributed to low birth weight babies, a category up to 5.5 pounds.

The results of Healthy Start have been extraordinary. Pittsburgh has a decentralized model comprised of six regional areas, including 45 neighborhoods, and the overall statistics for Pittsburgh are that infant mortality has declined 20 percent since the pilot project was there, and an estimated 61 percent in the results for women who have taken advantage of Healthy Start.

The statistics are not really comprehensive in Philadelphia, but there is a conclusion that infant mortality declined nearly 25 percent in the area serviced by Healthy Start.

This program has led to coordinated services from the Department of Agriculture's Special Supplement Food Program, which is an illustration of what Senator Kennedy was talking about on needs in other areas.

Dr. Koop has written extensively on this subject and has noted that for a $500 investment for women for Healthy Start, the savings are astronomical.

That is a very brief statement of my case, Madam Chair. My written statement contains a great deal more. I would be pleased to respond to questions.

[The prepared statement of Senator Specter follows:]

PREPARED STATEMENT OF SENATOR SPECTER

Chairman Kassebaum, it is a pleasure to testify before you and the Senate Labor and Human Resources Committee members concerning the need to authorize the Healthy Start demonstration projects, so that the program can expand and continue for another 5 years. I appreciate your willingness to hold this hearing and hope that what you hear today will encourage you to act quickly to authorize the program.

I plan to introduce legislation shortly to support the authorization of $100 million annually for 5 more years for Healthy Start. This will ensure both the renewal and growth of creative, community based strategies targeted to combat the problem of infant mortality and low birth weight babies in those areas with the greatest need.

Our nation's infant mortality rate is completely unacceptable: According to the Centers For Disease Control and Prevention (CDC), the United States ranked 22nd among industrialized nations in infant mortality, with a rate of 8.5 deaths per 1000 births in 1992. In many areas throughout the United States the infant mortality rate is much higher than the national average. For example, in 1993, in Memphis, TN, the infant mortality rate was 16.2 deaths per 1000 births; in Cleveland, OH, the infant mortality rate was 16.5 deaths per 1000 births. In my home State of Pennsylvania, the infant mortality rates for Pittsburgh and Philadelphia are 14.9 deaths per 1000 births and 14.1 deaths per 1000 births, respectively.

The truth is that the infant mortality rates for these cities, and many other counties throughout the country, are actually close to the infant mortality rates of Bulgaria and Romania which, according to the CDC, have the worst rates of all industrialized countries (16 deaths per 1,000 births and 23 deaths per 1,000 births, respectively). Our goal should be to achieve an infant mortality rate similar or better than that of Japan which has the lowest rate in the world at 4.8 deaths per 1,000

births. Included with my testimony are the latest CDC statistics on infant mortality by city and county for those counties with the worst rates in 1993. I encourage the members of this committee to review for yourselves the scope of the problem in your particular State.

We know that an infant's birth weight is the single most significant factor in predicting a baby's survival and health. Low birth weight babies are 40 times more likely to die in their first month of life. Each year about 7 percent, or 288,482, of the 4,000,240 babies born in the United States are born of low birth weight. Approximately 33,446 of these babies die before their first birthday. Approximately 1,000 of those deaths are preventable. Although the infant mortality rate in the United States fell to an all-time low in 1989, an increasing percentage of babies still are born of low birth weight. The Executive Director of the National Commission To Prevent Infant Mortality, Rae K. Grad, R.N., Ph.D., put it this way, "More babies are being born at risk and all we are doing is saving them with expensive technology."

I first saw 1-pound babies in 1984 when I was astounded to learn that Pittsburgh, PA had the highest infant mortality rate of African American babies of any city in the United States. I wondered how that could be true of Pittsburgh which has such enormous medical resources. It was an amazing thing for me to see a baby about as big as my hand, weighing about a pound. Some babies weigh as little as 12 ounces. They are human tragedies, carrying scars that last a lifetime.

Beyond the human tragedy of low birth weight are the financial consequences. Low birth weight children, those who weigh less than 5.5 pounds, account for 16 percent of all costs for initial hospitalization, re-hospitalization and special services up to age 35. The short and long term costs of saving and caring for infants of low birth weight are staggering. A study issued by the Office of Technology Assessment in 1988 concluded that $8 billion was expended in 1987 for the care of 262,000 low birth weight babies, in excess of that which would have been spent on an equivalent number of babies born of normal weight, averted by earlier or more frequent prenatal care. Low birth weight babies cost between $14,000 and $30,000 in the first year, with long term costs that can reach as much as $500,000 per baby. The Department of Health and Human Services estimated that by reducing the number of children born of low birth weight by 82,000 births, we could save between $1.1 billion and $2.5 billion per year.

We also know that in most instances prenatal care is effective in preventing low birth weight babies. According to the Department of Health and Human Services, every $1 spent on prenatal care saves $3 in health care costs later. Numerous studies have demonstrated that low birth weight does not have a genetic link but is associated with inadequate or lack of prenatal care.

Back in 1991, the Bush administration, under the leadership of Secretary Louis Sullivan, was quick to identify the problem of infant mortality and low birth weight babies and confronted it by introducing the concept of a 5 year Healthy Start demonstration project as a part of the FY 1992 budget request. Senator Harkin and I and others on the Appropriations Committee appreciated the immediate need to take a definitive step toward reducing infant mortality and ensured that $25 million in funding was immediately appropriated to initiate this program as part of the emergency supplemental appropriations bill in March of 1991. For FY 1992, we appropriated $64 million for the first year of these 5 year demonstration projects. The funding for these projects is scheduled to end with the $93 million appropriated for Healthy Start in FY 1996.

The Clinton administration has requested $75 million for FY 1997 so that existing projects can continue for another year and begin to train up to 30 new projects. However, I am concerned that the $75 million is not a realistic amount to finance both a continuation and expansion of current programs. Furthermore, the Healthy Start programs need a predictable time frame in order to properly plan and implement project goals. With $93 million in Federal funds already allocated to 22 existing projects in FY 1996, additional money will be necessary to ensure that our successful Healthy Start projects can continue, as well as have the capacity to train new projects. For this to be done properly, the program needs closer to $100 million and the stability of knowing Congress intends for the program to operate for an extended period of time. This will enable existing projects to plan properly for eventual self-sufficiency.

Although the general legislative authority of Section 301 of the Public Health Service Act was originally cited as the Healthy Start program's authorization, the evidence you will hear today should warrant a specific authorization for this program. The demonstration projects in Philadelphia and Pittsburgh have been extremely successful.

In the Pittsburgh area, a non profit 501(c)(3) organization was formed to administer the Healthy Start project. Pittsburgh has a decentralized model which is comprised of six service regional areas that include 45 neighborhoods. Core teams consisting of a community health nurse and outreach staff coordinate comprehensive outreach and individualized case management services for each of the service areas. Their goal is to identify women in need of care and link each woman to the appropriate resources. Our Pittsburgh project tells us that infant mortality has decreased 20 percent in the overall project area as a result of the Healthy Start program. Among those women who have taken advantage of case management in the Pittsburgh area Healthy Start project, infant mortality has been tremendously reduced—by an estimated 61 percent. The incidence of low birth weight babies has decreased to 6.5 percent for case-managed participants as compared to 12.7 percent for non-Healthy Start babies in the same communities.

Equally important are the dramatic improvements in the health care delivery system as a result of Healthy Start. The Department of Agriculture's Special Supplemental Food Program for Women, Infants and Children (WIC) services are now available at all pre-natal hospitals and community health centers. Greater use is made of primary care sites like community health centers so that preventive care, such as well baby and dental care for babies, is provided in the same physical facility as primary care. This provides for one stop shopping for health care for moms and their infants. Prenatal and gynecological care for the jail population is also greatly enhanced. Just this past weekend, the House of Hope in Braddock, PA opened to care for women and their children who are substance abusers needing residential treatment. In late summer, the Duquesne Healthy Start House is scheduled to open. This will be a house for homeless women with newborns to recuperate and adjust to their new family status. Transportation systems to previously unserviced areas has been secured and child care is also provided through the Pittsburgh Healthy Start project.

The Philadelphia Healthy Start project is run by the Philadelphia Department of Public Health. I visited the Kingsessing Recreation Center, site of the Philadelphia Project, in October of 1992 and witnessed for myself some of the excellent work done by the Philadelphia Healthy Start Project. Since the Healthy Start program began, the Philadelphia program believes infant mortality has declined nearly 25 percent. By comparison, the infant mortality rate actually rose between 1992 and 1994 in Philadelphia neighborhoods outside of the Healthy Start Project Area, from 12.2 deaths per 1,000 births to 13.3 deaths per 1,000 births. Contracts with over 60 clinical and community based organizations have enabled the program to initiate extensive street outreach, including home visitors and neighborhood lending closets. A Healthy Start outreach van was purchased and is extensively used, and local clinics have extended hours on Saturdays and evenings. A broad public awareness campaign on Healthy Start's services was also undertaken and is ongoing. Past efforts include the production of a teen staffed musical called "Choices" to convey information about teen pregnancy to youth at three area high schools.

I have long been convinced and have spoken on the Senate floor on many occasions concerning the fact that the best health care reform is incremental health care reform, building upon the successes of our current system. On the first day of the 103rd Congress and the 104th Congress, I introduced my own health care reform bills, both numbered S. 18, taking just this approach. My proposals contained many of the insurance market reforms to ensure portability that are contained in S. 1028, the Chairman's own health care reform bill. S. 18 also contained an authorization to extend and expand the Healthy Start program. As the Chairman knows, during floor consideration of her bill, I was prepared to offer a Healthy Start amendment. Recognizing the obstacles she and the Ranking Member, Senator Kennedy, faced in getting this legislation enacted, and after consultation with them, I agreed to withhold my amendment. I am pleased that, consistent with those consultations, Chairman Kassebaum has conducted this hearing.

Just as with insurance reforms, we should act now to take this additional step to authorize the Healthy Start program. Such action will reduce unnecessary health care costs for caring for low birth weight babies. More importantly, it will improve access to health care for the millions of low income pregnant women and their future children who will benefit from this legislation. We owe it to these women to take this important step forward.

The CHAIRMAN. I certainly thank you, and as I said earlier, it is because of your dedicated interest in this program and in the marshalling of funds to support it that it has had the success that it

has. We will be hearing from some witnesses who will provide testimony to exactly what it has accomplished.

I agree with you, it is shocking to think that in this day and age, we could have a percentage as high as 10.8 for Wichita, KS. We tend to believe that there is good care and that a community of that size should provide that kind of care, and yet it is not always there and available, nor do we recognize exactly why.

Senator SPECTER. I did not realize the statistics were that high for Wichita and so low in Japan; I might have chosen to have been born in Tokyo had I known that, Madam Chairwoman.

The CHAIRMAN. Instead of Wichita.

Senator SPECTER. Instead of Wichita—but I came in at a robust 10 pounds, 8 ounces, so I was not in any danger.

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. Just very briefly, Senator Specter, I am sure you are aware of what is happening now in most of the States in terms of the increasing numbers of children who are not covered with health insurance. In my State over about the last 4 years, that number has more than doubled, and the projection lines are increasing all over the country.

We had 412,000 children receiving Medicaid assistance in 1994. Medicaid paid for 24 percent of all births in my State. And the total number of children without health insurance is increasing. We are finding with these Medicaid cuts the repeal of our fundamental commitment to children and to pregnant women as well as the disabled. I think this is a real crisis.

I am all for the reauthorization—as you know, we tried to get the reauthorization in our manpower legislation and were not successful in doing that—and I admire the fact that we are going to continue the President's call for about $72 million for next year. I think it is important that we get authorization if we possibly can, and I will do everything I can to do that.

The larger issue of what is happening to these children and the withdrawal of commitment to both children and expectant mothers and the cutbacks in those proposals, I think is threatening the well-being of needy and poor children. And the reductions in terms of health insurance which are taking place particularly with regard to children are also rather ominous.

So we are going to need to have a clear and powerful voice that is going to speak out for those children. I do not know what has happened in Pennsylvania in the last year or two in terms of the total increases in Medicaid and uninsured children and what the flow lines are there, but I doubt if they are very different from those of other States, so we are going to have a lot of work to do both on this bill and hopefully on Medicaid. I look forward to trying to find ways of working together in those areas.

Senator SPECTER. Senator, those flow charts for Philadelphia are a lot like the flow charts for Boston—first cousins.

Senator KENNEDY. We have in Boston, as you have in Pittsburgh and in Wichita, some of the great medical institutions, but if you look at certain sections—and we will be hearing later on from Jackie Jenkins-Scott—of Boston, these incidences are far in excess of even the figures you have given in a broad number. And in more recent times, some of the hospitals have developed these programs

for good care, for prenatal care and postnatal care for mothers. One of the successful programs involves vans that go out. They have had some success, and they have been much more organized and targeted and structured. There is a great need in those pockets. As you and Senator Kassebaum have pointed out, we are not doing very well as a Nation, and I for one am very concerned that the size of the cutbacks that are being proposed for Medicaid will accelerate this deterioration rather than address it. But that is just an editorial comment.

Senator SPECTER. Senator, Senator Harkin and I will be offering on the budget resolution now pending an amendment to have $2.7 billion for our subcommittee to bring it to a par with what we had last year, what we finally worked out with that identical amendment in April which got us through the difficulty. So we are working hard to try to make as many ends meet as we can.

Thank you very much.

The CHAIRMAN. Thank you very much, Senator Specter. We appreciate your testimony.

It is a pleasure now to welcome Dr. Louis Sullivan back to the witness table. Dr. Sullivan, as has already been acknowledged, served for 4 distinguished years as Secretary of Health and Human Services throughout the entire Bush administration.

As just brief background, because I think most already know, he graduated magna cum laude from Morehouse College in 1954 and earned his medical degree cum laude from Boston University School of Medicine in 1958.

I think more importantly, Dr. Sullivan, you have been a pioneer in caring in so many different fields, and I am very appreciative of your willingness to rearrange your schedule to come here today, because it is graduation time at Morehouse College. I know you must leave shortly to get back. So we appreciate very much your coming this morning.

STATEMENT OF LOUIS W. SULLIVAN, M.D., PRESIDENT, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA, AND FORMER SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. SULLIVAN. Thank you, Madam Chair. I am very grateful for this opportunity to appear before this committee. Certainly working with you and Senator Kennedy and the other members of this committee during my tenure as Secretary was indeed a great pleasure, so it is an honor for me to have this chance to address you again.

First, let me say that I applaud the concern that this committee has for this very important national issue. Our children are our Nation's greatest resource. One of the strengths of this program from the beginning has been the bipartisan support that we have enjoyed, particularly for children at risk.

Our children continue to need our help. I think we are all concerned about the fact that while the relative affluence of seniors over the past two decades has improved, the level of poverty among children has increased.

According to the latest figures released by the National Center for Health Statistics, the infant mortality rate in 1992 was 8.5

deaths per 1,000 live births. This means that we continue to have one of the highest infant mortality rates among industrialized nations around the world. Countries that are doing better than we are include not only Japan, but Sweden, Ireland, Canada, and others.

We have made progress in our efforts, but much progress is yet to come. We cut infant mortality by some 25 percent between 1986 and 1992. Since 1970, we have cut the rate of infant mortality in half because of prevention efforts as well as new technologies that have been developed.

But in spite of this, our infant mortality rate continues to be too high.

During my tenure as Secretary, we introduced Healthy People 2000 in September of 1990. That report, which had some 298 specific health promotion and disease prevention goals, included reducing the infant mortality rate from the level of 9.8 at that time to less than 7 infant deaths per 1,000 births by the year 2000. The Healthy Start program was one of the responses to that effort.

There is also a shocking disparity in infant mortality rates between the general population and our poor and minority citizens. As you know, African American babies die at a rate 2½ times higher than that for white infants. So I maintain that our poor communities continue to need comprehensive, targeted and specific programs like Healthy Start, programs that will prevent unnecessary death and disability among our Nation's youngest citizens.

I maintain that Healthy Start is a sound investment to promote good health and better use of our Nation's economic resources.

Fortunately, almost all of the many health concerns facing our children are preventable. These include low birth weight, inadequate or absent prenatal and postnatal care, malnutrition, lack of immunizations, and other problems. So a strong, credible, organized program with a well-evaluated prevention effort can directly lower infant mortality rates.

There is also a growing body of evidence proving that prevention efforts avert more costly expenses down the road. For every low birth weight baby prevented by proper prenatal care, it is estimated that our U.S. health system saves between $14,000 to $30,000 in health care costs. These are data from the Office of Technology Assessment.

In fact, for every $1 spent on routine prenatal care for high-risk women, more than $3 is saved in after-delivery costs.

There are long-term savings in other areas as well. Because lack of proper prenatal and postnatal care are strongly linked in later life to low earning capacity, low educational attainment, low occupational status and other economic and social burdens, the cost savings from the Healthy Start program are substantial over time.

Senator Kassebaum, you and Senator Kennedy and the other members of this committee are to be congratulated for developing a bill that will address several significant problems in our health care system. Preventing illness is a sound national policy. We must generate greater focus on prevention if we hope to foster a substantial improvement in the health status of our citizens.

Healthy Start is a federally-funded, locally administered program that works. In 1991, as already noted, during my tenure as Sec-

retary, the Department of Health and Human Services funded demonstration programs in 15 communities across the Nation. I was pleased that the National March of Dimes added their funding to add six more communities to this effort. Our goal was to reduce infant mortality by half in those communities over a 5-year period. These communities are listed in my testimony.

Each of these communities designed a program of medical and social services based on community input and needs of the local community. Working together, I believe that Healthy Start is one of the most important and one of the most effective Federal and local partnerships to assist our children.

While a 5-year study to evaluate this program has not been completed, the local data that are available for some of the communities indicate that the program has been very helpful in reducing infant mortality and other problems with pregnancy.

In Chicago, for example, in the Healthy Start program, infant mortality dropped by 28.6 percent between 1990 and 1994. By way of comparison, the State of Illinois lowered infant mortality by about 16 percent during the same time period—half the impact of the Healthy Start program.

Madam Chair, I appear here today fully convinced that Healthy Start is an indispensable, fiscally responsible, lifesaving governmental effort to protect our children. I am proud that this program was developed, introduced, funded and first administered during my tenure as Secretary of Health and Human Services. I urge you and your colleagues in the Senate to maintain your strong fiscal support and wise guidance of this effort. I would even be so audacious to ask that you expand this program to reach millions more who live in nonHealthy Start communities. Healthy Start is a farsighted investment in our children, in their health, and in the future of our Nation.

Again, Madam Chair, I thank you and the committee for the opportunity to present my views on the Healthy Start program. I would be pleased to respond to any questions.

[The prepared statement of Dr. Sullivan follows:]

PREPARED STATEMENT OF LOUIS W. SULLIVAN, M.D.,

PRESIDENT OF THE MOREHOUSE SCHOOL OF MEDICINE

Thank you, Madam Chair. I applaud this committee's continued support and concern for our Nation's children. One of the great strengths of Healthy Start, right from its beginning in 1991, has been the steadfast bipartisan effort to assist our Nation's children, particularly those most at-risk.

Our children need our help. Millions of them are at grave risk, especially those children in underserved areas, in our economically disadvantaged neighborhoods, in our rural areas, and in our minority communities. According to the latest figures released by the National Center for Health Statistics, the infant mortality rate in 1992 was 8.5 deaths per 1,000 live births, still one of the highest rates of infant mortality among industrialized nations, placing this country far behind Japan, Sweden, Canada, and Ireland, among other countries. We have made some progress. From 1986 to 1992, infant mortality was cut by about 25 percent. Since 1970, the infant mortality rate has been cut in half because of prevention efforts and the advent of new technologies. But our Nation's infant mortality rate is still too high. We must redouble our efforts to reach the national goal of less than 7 infant deaths per 1,000 live births by the year 2000, as outlined in the health promotion/disease prevention goals that I released as U.S. Secretary of Health and Human Services in September, 1990.

Madam Chair, there is also a shocking disparity between the infant mortality rates for the general population and for our poor and minority communities. African-American infants die at a rate almost two-and-a-half times higher than for white infants. Our Nation's poor and minority communities need comprehensive, targeted, and sustained programs like Healthy Start to prevent unnecessary death, disease, and disability among our youngest children.

Healthy Start is a sound *investment* to promote good health and better use of our economic resources. Fortunately, almost all of the many health concerns facing our children are preventable——concerns that include low birthweight, inadequate or absent prenatal and post-natal care, malnutrition, lack of immunizations, and other problems. A strong, credible, properly funded, and well evaluated prevention effort can directly lower infant mortality rates.

There is also a growing body of evidence proving that prevention efforts avert more costly expenses down the road. For every low birthweight baby prevented by proper prenatal care, the U.S. health system saves between $14,000 and $30,000 in health care costs, according to the Office of Technology Assessment. In fact, for every $1 spent on routine prenatal care for high-risk women, more than $3 is saved in after-delivery costs. There are long-term savings in other areas, too. Because lack of proper pre-natal and post-natal care are strongly linked in later life to low earning capacity, low educational attainment, low occupational status, and other economic and social burdens, the cost savings from the Healthy Start program could be substantial over time.

Senator Kassebaum, you and Senator Kennedy, and other members of this committee, are to be congratulated for developing a bill that will address several significant problems in our health care system. Preventing illness is a sound national health policy. We must generate a greater focus on prevention if we hope to foster a substantial improvement in the health status of our citizens.

Healthy Start is a federally funded, locally administered program that works. In 1991, during my tenure as Secretary, the Department of Health and Human Services funded demonstration programs in 15 communities across the Nation to find ways to reduce infant mortality, with the goal of cutting infant mortality by half in those communities over a 5-year period. These communities (Aberdeen Area Indian Reservation, Baltimore, Birmingham, Boston, Chicago, Cleveland, Detroit, Indiana's Lake County, New Orleans, New York City, Oakland, Philadelphia, Pittsburgh, the Pee Dee Region of South Carolina, and Washington, DC.) each designed a program of medical and social services based on community input and population needs. Working together, I believe we have proven that Healthy Start is one of the most important, and most effective, Federal and local partnerships to assist our children. While a 5-year study to evaluate the success of Healthy Start has not been completed, the local data now available for some of the communities indicates that the program has been very helpful in reducing infant mortality and other pregnancy problems. For example, in the areas of Chicago participating in the Healthy Start program, infant mortality dropped by 28.6 percent from 1990–94. By way of comparison, the State of Illinois lowered infant mortality by about 16 percent during the same time period. I am certain that we will see similar success stories as more data becomes available.

Madam Chair, I appear here today fully convinced that Healthy Start is an indispensable, fiscally responsible, and lifesaving governmental effort to protect our children. I am proud that it was developed, introduced, funded, and first administered during my tenure at HHS. I urge you to maintain your strong fiscal support and your wise guidance of this effort. I even ask that you expand the program to reach those who live in non-Healthy Start communities. Healthy Start is a farsighted investment in our children and in our Nation.

Again, Madam Chair, I thank you and the committee for this opportunity to present my views on the Healthy Start program. I would be pleased to answer your questions.

The CHAIRMAN. Thank you, Dr. Sullivan, and as I said, with your being President of the School of Medicine at Morehouse and it being commencement week, we know your schedule is tight. I would just like to briefly ask a question.

There have been other infant mortality programs that we have had. Why did you feel that we needed this type of initiative, and in what way has it been different from past efforts?

Dr. SULLIVAN. Thank you, Madam Chair. The reason I felt this program was needed was that it provided for local input into the

design and organization of the program. And as previous comments during Senator Specter's appearance would indicate, the problem here is not the lack of technology or lack of health professionals, but really the inability to connect those resources with our general population.

This is a program where the health professions community needs the help of other leaders in the community because the problems of high infant mortality are related to lack of prenatal care.

I have often maintained that we have the most sophisticated and advanced health care system in the world—but it is of no use if it is not accessible to people, if they do not use it. Too many of our citizens do not recognize or realize the importance of early prenatal care in pregnancy, the important difference in pregnancy outcomes that will result if medical conditions are found early in pregnancy and are treated, rather than later, when the mother comes in for delivery. So this program is one where there is local input, and our template for this was not to have a Federal program that would have a cookie-cutter approach going across the Nation, but rather a partnership where, with these 15 different cities, we knew we would have a number of different approaches that the communities themselves felt would be the best approach to this program.

The CHAIRMAN. Thank you very much.

Senator Kennedy.

Senator KENNEDY. I think that that has been one of the advantages, particularly in these outreach programs—encorporating language, customs and other traditions of the local community. As Senator Kassebaum pointed out, it was not long before we had these comprehensive child development programs that built on the Beethoven Project in Chicago that went on for 5 years. We had a program in Boston which identified prenatal care and also followed the children up to 5 years of age, with one-stop shopping services. They are successful at reducing infant mortality, and the range of different services these programs offer for these children seems to me to be the way to go.

I have a broader question. We have really learned these lessons year in and year out. In the last 2 or 3 years, we have had comprehensive reports from the Carnegie Commission about nutrition after the first year or year and a half and how the effects cognitive development and the entry level of children going into school. We know the importance of early intervention. We know the importance of getting good health care and prenatal care. These are lessons that we have learned year after year after year.

So my real question to you is when do you think we are going to say as a society that this is our Nation's future, and it is our priority? When do you think we are going to make a strong commitment to do something? The interest in children and what has to be done about them goes right across party lines. I suppose the issue is in terms of resources and maybe about where we are going to allocate resources, but there really is not any difference that I have seen in these conclusions which you have and which the previous administration had in terms of intervention with children, earlier intervention, services for prenatal and postnatal, nutrition and so on.

So the question is how are we going to really motivate society. You have been an educator; you are a leader; you have been an important Cabinet Member. What do you think we ought to be doing to try to marshal those so we can really give focus and attention on really giving a healthy start to each child in the country?

Dr. SULLIVAN. Thank you, Senator Kennedy. First of all, I would say that certainly, what we have learned over the past couple of decades is that the education of our citizens on health issues is a long-term and complex problem. Yes, we do have these reports and many studies. Immunization is a comparable issue, and I think it is a shame that we are the Nation that developed the polio vaccine and developed all of the other vaccines, but there are many other nations, including some developing nations, that are doing better than we are in terms of getting their children immunized.

Senator KENNEDY. Yes. We are the second-worst in the Western Hemisphere, and we produce 80 percent of the vaccines. I can take you to Bedford and Fall River, where 65 to 70 percent of the children are not vaccinated; and a lot of that is cultural and a lack of education and outreach programs—and it is cost. Even though we produce a lot of the funding for those vaccines, they are paid for at the Federal or State level, and they still cost.

But I agree with you that we have to define outreach, but this is such a natural thing for Americans to be focused on and to give energy to and resources to try to do something for children, so I would be interested, finally, in your insight on what we ought to be doing.

Dr. SULLIVAN. Well, what I really think it requires, and what I think the Healthy Start program tries to do, is really a balance of responsibility. I think the Federal Government, the State and local governments and the private sector do have a responsibility to see that the infrastructure is there. And it is clearly that responsibility that, as a society, I do not think we can walk away from.

But also, part of the answer has to be the individual responsibility of our citizens themselves, and of course, I have stressed that as well. So that is why, as I mentioned earlier, that local input is so important, because what we are talking about fundamentally is how people organize their lives, what their values are, what they consider important, and what they consider relevant to them. You know, one of the problems, of course, in dealing with adolescents on health problems is that they do not believe that all the things you tell them really apply to them, but they apply to other people.

So what we have to do is a better job, and it means a long and sustained job, of educating and motivating our citizens. And of course, frustration comes because the changes do not occur overnight. But we are making progress. As I mentioned, we have reduced mortality since 1970 by half, but the problem is it has not come down rapidly enough.

We are seeing improvements in immunization rates, whereas we had lapsed 5 or 6 years ago—this was a major crisis during my tenure as Secretary—we are swinging up, but we still have a lot to do.

Seatbelt use is another example. When I started as Secretary in 1989, only 47 percent of America's drivers were using seatbelts, and there was a striking difference among States. I think some-

thing like 80 percent of citizens in Hawaii were using seatbelts versus 17 percent in Mississippi. Now that 47 percent has become 67 or 68 percent. So we have made progress, but the question is why can't we reach that other 32 percent. The data are very clear—if you use a seatbelt and you have an accident, your chances of coming out alive or without a major injury are so much better using a seatbelt. But yet in spite of this—and these data are not new—we really have a slow response by citizens.

So we have to find ways to really educate our citizens so that they see these things that we in the health community are saying are really relevant to them. That is why we in the health community say we need help from other people—from clergy, from the boys and girls clubs, from community leaders—because fundamentally, these are issues related to lifestyle. There is no question that our biomedical research enterprise is the greatest in the world. I could cite many statistics to show you that. Half of the Nobel Prizes ever awarded have been to Americans, although we represent only 6 percent of the world's population. Half of the new blockbuster drugs that are produced come from American pharmaceutical companies. And again, I would mention our leadership in developing vaccines and so on.

So clearly, we are leaders. We have people coming from all over the world to our educational institutions to get the kind of training they cannot get in their own countries.

So it is a paradox, it is a frustration that we have these problems, but I see them as not failings of the health care system but failings in our society, and that is why we need broad participation of other leaders in our society.

I would also say that while it takes time, and the results do not come as rapidly as we would like, the last thing we should do is despair and walk away from a program. It will work, but it will take time.

Senator KENNEDY. Thank you very much.

Thank you, Madam Chairman.

The CHAIRMAN. Thank you.

Senator Faircloth.

Senator FAIRCLOTH. Thank you, Madam Chairman.

I understand you will have to leave, Dr. Sullivan, so I have just one question that has bothered me. Is the infant mortality much greater and is there a widespread difference between young unwed mothers and women who are married?

Dr. SULLIVAN. Well, yes, that is the case. The factors that go into that include the fact that, first, youth contributes to that because obviously a teenager who has a baby has a higher infant mortality risk, a higher risk of low birth weight. But there is a difference between an unwed teenager and a married teenager; clearly, the institution of marriage conveys a number of benefits to help that.

But other things contribute, too. Drug use obviously contributes to infant mortality; poor nutrition, etc. So that yes, clearly, these factors including youth and marital status do contribute to that.

Senator FAIRCLOTH. If I understood your testimony, you said that it was more of an educational process, that the facilities are generally there for the prenatal care or vaccinations, and that it was

a matter of getting the mothers to utilize them. Did I understand that correctly?

Dr. SULLIVAN. That is correct. Again, as I said, it really is a partnership. I think those of us in positions of power and responsibility have to exercise that responsibility to see that they are there; in some places, they are not. But indeed, you are quite correct that in many instances, the facilities are there, but people are not using them, and that is where the educational effort is needed.

In fact, one of the features of the Healthy Start program is the educational effort as well as the coordination of the services—the nutrition services from the Department of Agriculture, seeing that the mothers who are eligible for Medicaid are enrolled in the program, and all those other things. So it really looks at infant mortality as simply the symptom of a larger issue. But certainly, we do have the problem of the facilities often being there, but people not using them.

Senator FAIRCLOTH. Thank you.

The CHAIRMAN. Thank you very much, Dr. Sullivan. We appreciate your being here, and we wish you a good week as you wrap up commencement.

Dr. SULLIVAN. Thank you, Madam Chair. We are very pleased that tomorrow, we will graduate our 401st physician at the Morehouse School of Medicine since we started.

The CHAIRMAN. That is wonderful. Thank you.

It is a pleasure to welcome next the administrator of the Health Resources and Services Administration, Dr. Ciro Sumaya, who is back again to offer testimony. Welcome again, Dr. Sumaya.

Dr. Sumaya is responsible for innovation in health care delivery and health professions education and training nationwide. Before coming to HRSA, Dr. Sumaya served as associate dean for affiliated programs and continuing medical education at the University of Texas Health Science Center in San Antonio.

Because of your specialty in pediatrics and pathology, and your having written many scientific articles and papers on such matters, it seems very fitting to be able to call on you this morning to offer your comments on this program and oversight on the Healthy Start demonstration project.

I would like to apologize, Dr. Sumaya. I am going to have to leave, and Senator Faircloth is going to take over the presiding position right now, but I want you to know how much I appreciate your coming.

STATEMENT OF DR. CIRO SUMAYA, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. AUDREY NORA, DIRECTOR, MATERNAL AND CHILD HEALTH BUREAU, AND DR. THURMA McCANN, DIRECTOR, DIVISION OF HEALTHY START

Dr. SUMAYA. Thank you, Madam Chairman and members of the committee. I am accompanied this morning by Dr. Audrey Nora, director of HRSA's Maternal and Child Health Bureau, and Dr. Thurma McCann, who is director of the Division of Healthy Start within HRSA's Maternal and Child Health Bureau.

I am pleased to have this opportunity to share with you our efforts to reduce infant mortality in the United States through this demonstration program called the Healthy Start Initiative. In my testimony today, I will summarize the progress Healthy Start has made toward improving maternal and infant health in 22 communities across the country and describe the Department's plan to benefit from what we have learned.

Infant mortality reduction continues to be among the Nation's highest priorities, and although progress has been made, I think, as has been clearly pointed out, we still have a long way to go. The United States ranks 23rd among industrialized nations in our infant mortality rate, and there continues to be a very large disparity between the infant mortality rate for some minority populations and the general population.

I want to briefly add to some of the earlier comments on the origins and development of this program because I think it is very important to bring that out.

In 1989, a White House Task Force on Infant Mortality recommended that actions be taken to address persistently high infant mortality rates in this Nation. Healthy Start emerged as a demonstration program in 1991 and has been renewed in annual Labor-HHS appropriations bills ever since.

The Healthy Start program was based on the premise that new, community-based strategies were needed and should come from communities in order to attack the causes of infant mortality and its major precursor, low birth weight, especially among high-risk populations. But again, I think that underlines some of the comments that Dr. Sullivan made from the community standpoint and from the personal needs and the personal features that tie in directly with infant mortality rate problems.

The five principles underlying the Healthy Start strategy are innovation, community commitment, increased access to health care, services integration, and personal responsibility. The program was designed as a unique attempt to pull together the working commitment of local families, volunteers, nonprofit organizations and private companies, in addition to the relevant health care and social service providers.

Applicants for Healthy Start grants were sought among urban and rural communities with infant mortality rates at least 1.5 times the national average. In the fall of 1991, 15 applicants—13 urban and 2 rural—were awarded grants with the goal of reducing infant mortality in their project areas by 50 percent over a 5-year period. In late 1994, 7 additional communities—5 urban and 2 rural—were awarded Health Start Special Projects grants.

And where is Healthy Start today? Twenty-two current Healthy Start projects serve communities from Florida to California, from Boston to Birmingham, the Northern Plains to the Mississippi Delta. Over the 3 operational years of fiscal years 1993 to 1995, the projects have translated the concept of community-based service integration into a wide variety of infant mortality reduction strategies, each tailored to address unique community needs.

These programs and activities have addressed the following objectives: 1) to significantly reduce infant mortality and increase the number of women receiving early prenatal care; 2) to build and

strengthen community-based systems of care; 3) to increase access to and utilization of quality primary care and support services; 4) to create enabling services and coordinate existing programs that overcome barriers to health care; and 5) to address the differences in the health and infant mortality rates between minorities and the general population.

Madam Chairman, and now Senator Faircloth, I have included in my full statement several examples of local Healthy Start activities aimed at achieving these objectives.

A critical national evaluation of the Healthy Start program is in place through a contract with Mathematica Policy Research, Incorporated. This cross-site evaluation of the 15 original Healthy Start projects consists of both a process and an outcomes analysis.

The process evaluation of Healthy Start will detail the individual characteristics of the 15 projects, their health and social services infrastructure, organizational characteristics, and descriptive information about the type and scope of local interventions.

The outcome evaluation entails a quantitative analysis of the overall success of the Healthy Start program through assessments of multiple program outcomes such as infant mortality, low birth weight incidence, and improved maternal and child health, using client-specific data as well as secondary data sources.

The national evaluation is a 5-year effort with a final report due in 1998. In addition to the national effort, the 15 original Healthy Start projects have the administrative option of conducting local evaluations, and each of the 7 special projects is required to conduct local evaluations.

The Healthy Start initiative also features an aggressive national and local public information and education component that raises awareness of the problem of infant mortality and promotes prenatal care and other healthy behaviors. The highlight is a national public service campaign, developed with the assistance of the Advertising Council.

A recently developed set of public service advertisements which will be released this summer urges women to seek early and regular prenatal care to avoid putting their babies' health on the line. The campaign will feature the two new toll-free numbers—one for English-speaking callers and one available for Spanish-speaking callers. These national prenatal care hotlines will connect callers to the Healthy Start project or State maternal and child health office closest to where they live.

As we look to the future, the initial Healthy Start demonstration projects will be concluding, and HRSA is working very actively with the projects in a number of ways to sustain and replicate effective program models to decrease infant mortality. With a national investment of $460 million, the Healthy Start program has also had valuable impact in addressing health, social and economic issues beyond infant mortality reduction. The Healthy Start experience with involving communities in public health programs ought to be used as a learning lab for both urban and rural communities across the country, especially for programs targeting low-income and underserved populations.

I can say that we have indeed broadened our knowledge base. It would be a shame for our country to halt these advances now.

Commencing with fiscal year 1994, HRSA plans to take the lessons learned to date and build on these successful experiences through a two-pronged approach that will maximize the use of financial resources, as well as knowledge and experience. Many of the current projects will be continued with an additional role, that is, these projects will become "teachers," sharing the "how to" of their successes and the "what" and "how not to" from their experience and knowledge. Their students will be other communities and States suffering from the ravages of high infant mortality and low birth weight infants.

We will call these "teachers" Healthy Start resource centers, mentoring to those seeking knowledge while also continuing their effective strategies within their own communities.

The second prong of our approach will be the funding of new communities to operationalize successful models applicable to their respective communities, building coalitions and the mechanisms for sustainability, eventually themselves becoming resource centers.

This approach will further expand integration of Healthy Start activities to other HRSA-managed activities such as Title V maternal and child health block grants, the community and migrant health center system, and many other existing State and local services.

We believe this plan will maximize the effective use of resources and their impact on infant mortality reduction.

In closing, Senator, I would like to emphasize that Healthy Start is a driving force for empowering individuals and communities to take charge, promoting healthy mothers, infants and families, building stronger communities, States, and a Nation, to take on tomorrow's challenges while conserving future resources.

This concludes my testimony, and we will be happy to answer any questions you may have.

[The prepared statement of Dr. Sumaya follows:]

PREPARED STATEMENT OF CIRO V. SUMAYA, M.D., M.P.H.T.M.

ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the committee, I am Dr. Ciro Sumaya, Administrator of the Health Resources and Services Administration (HRSA). I am accompanied this morning by Dr. Audrey Nora, Director of HRSA's Maternal and Child Health Bureau (MCHB) and Dr. Thurma McCann, Director of MCHB's Division of Healthy Start. The Division of Healthy Start provides leadership and administration of the Healthy Start Initiative.

I am pleased to have this opportunity to share with you our efforts to reduce infant mortality in the United States through a demonstration program called the Healthy Start Initiative. In my testimony today, I will summarize the progress Healthy Start has made toward improving maternal and infant health in 22 communities across the country and describe the Department's plan to benefit from what we have learned.

Infant mortality—the death of babies before their first birthday—has been a tragic public health problem during the past 100 years that continues to be among the highest National priorities. It is addressed through both research and activities that seek to reduce the numbers.

During this past century, progress has been made through public and private studies and grant programs. Nevertheless, the United States continues to have one of the highest infant mortality rates among industrialized nations: the United States infant mortality rate ranks 23rd compared to other industrialized nations, with countries such as Northern Ireland, Belgium, Japan, and Singapore having

lower infant mortality rates than we do. And there is a large disparity between the infant mortality rates for some minority populations and the general population. For example, the infant mortality rate of African-Americans is more than twice that of whites.

In 1989, a White House Task Force on Infant Mortality recommended that actions be taken to address persistently high infant mortality rates in this Nation. A HRSA-convened Interagency Committee on Infant Mortality more specifically recommended targeting the reduction of high infant death rates associated with ethnic and racial populations. Healthy Start emerged as a demonstration program in 1991, with funds appropriated initially under P.L. 102–27, "The Dire Emergency Supplemental Appropriations Act for FY 1991," and renewed in annual Labor-HHS appropriations bills ever since.

The Healthy Start program was based on the premise that new community-based strategies were needed and should come from communities in order to attack the causes of infant mortality and it major precursor, low birthweight, especially among high-risk populations. The five principles underlying Healthy Start's strategies are: innovation; community commitment and involvement; increased access to health care; service integration; and personal responsibility. The program was designed as a unique attempt to pull together the working commitment of local families, volunteers, nonprofit organizations, and private companies, in addition to the relevant health care and social service providers.

Applicants for Healthy Start grants were sought among urban and rural communities with infant mortality rates at least 1.5 times the national average. In the fall of 1991, 15 applicants (13 urban and 2 rural) were awarded grants with the goal of reducing infant mortality in their project areas by 50 percent over a 5-year period. FY 1991 funds supported year-long comprehensive planning activities; the projects began serving clients in FY 1993.

Based on strong bipartisan support for Healthy Start and a firm commitment by the Clinton administration to reduce infant mortality, in late 1994, 7 additional communities (5 urban and 2 rural) were awarded Healthy Start Special Projects grants. These communities had infant mortality rates as high as the original 15 projects, and already had operational community consortia and infant mortality reduction programs in place. The goal of these Special Project grants is to significantly reduce infant mortality rates in their target areas over a 2-year period. Because these 7 additional communities had a stable infrastructure and plan of action, Federal funds reinforced their ability to be more targeted in their efforts to reduce infant mortality.

The 22 current Healthy Start projects serve communities from Florida to California, Boston to Birmingham, the Northern Plains to the Mississippi Delta. Over the 3 operational years of FY 1993–95, the projects have translated the concept of community-based service integration into a wide variety of infant mortality reduction strategies, each tailored to address unique community needs and to overcome barriers to care. These programs and activities have addressed the following objectives:

• **To significantly reduce infant mortality and increase the number of women receiving early prenatal care.** The 1993–94 provisional vital statistics, as reported by the 15 original Healthy Start projects, indicate some success in reduction of infant mortality rates across the sites, as compared to the 1984–88 baseline, although the precise contribution of Healthy Start funding cannot yet be measured. Many projects also recorded fewer low birthweight infants; more women abstaining from smoking, alcohol and drugs during pregnancy; and substantial increases in the number of women receiving adequate prenatal care.

• **To build and strengthen community-based systems of care.** Healthy Start challenges communities to actively address the medical, behavioral and psychosocial needs of women and infants. Each project has developed a strong coalition of local and State governments, providers, corporations and businesses, schools, religious groups, and neighborhood organizations. These coalitions help guide the local projects, offer resources to support programs and provide contacts to support efforts to sustain the programs after Federal funding ends.

Example: In Philadelphia, 65 community-based organizations actively participate in the Philadelphia Healthy Start Provider Council, which facilitates collaboration and communication among all coalition members.

Example: In Cleveland local residents act as "Neighborhood Consortia Builders" to motivate members of the community and area businesses to play an active financial role in their Healthy Start project.

• **To increase access to and utilization of quality primary care and support services.** Healthy Start projects have enhanced service delivery systems by integrating existing programs, including the services of State/local maternal and child health agencies and community health centers. In many of these communities,

Healthy Start projects also expanded provider capacity with the services of obstetricians/gynecologists, perinatologists, pediatricians, advanced practice nurses and other professionals. Clinics' and providers' visiting hours have been expanded. To encourage women to take advantage of these health care and support services,each Healthy Start project has developed extensive outreach and case management programs. Some projects employ and train community residents as outreach workers to seek out pregnant women and families and oversee their experiences as Healthy Start clients. Since these outreach workers are also residents of the target neighborhoods, they speak the language of the community and know first-hand how to reach those who most need the help.

Example: Pittsburgh Healthy Start workers go to local band on paydays to do prenatal care registration and to laundromats, where outreach workers have an opportunity to talk with women.

Example: At the Northern Plains site—which provides services to 19 Native American tribal communities in Iowa, North Dakota, South Dakota, and Nebraska—case managers help women through pregnancy, childbirth and the challenge of new parenthood. The program has yielded fewer pre-term births; increased involvement by males and other community members; and increased immunization rates.

• **To create enabling services and coordinate existing programs that overcome barriers to health care.** Healthy Start projects offer their clients a range of support services, including on-site Medicaid/WIC eligibility certification, transportation, child care, parenting information, nutrition education, peer support for young parents, adolescent empowerment and self-esteem activities, home visiting, male involvement programs, substance abuse treatment and counseling, housing and employment assistance.

Example: Northwest Indiana Healthy Start transports clients to prenatal care and pediatric appointments in mobile "MOM" vans.

Example: The Baltimore City Healthy Start encourages men to be involved in their partners' pregnancies and their children's lives through its Men's Services Program, which has served as a model for the Nation. The program requires fathers to attend prenatal care appointments and parenting classes, while offering them a therapeutic support group in which to share their feelings, successes and frustrations about fatherhood.

• **To address the differences in the health and infant mortality rates between minorities and the general population.** The lack of cultural sensitivity and the ability to reach out to minority population groups often have impeded the delivery of prenatal services. The projects have developed culturally sensitive "one-stop" service centers within the community to ensure that services are provided in a manner that is comfortable to culturally diverse populations.

Example: The Chicago project, which has the highest concentration of Hispanics, has established *Esperartza Hope*, a "one-stop" shop with comprehensive bilingual staff. This center has already reached capacity and has a waiting list for prenatal care. These centers sponsor ethnic ceremonies, activities and festivals and produce educational materials in languages appropriate for their clientele.

Example: In New Orleans, with its unique cultural heritage, Nanans (godmothers) and Parrains (godfathers) identify residents who are pregnant; facilitate their entry into services; often transport the clients to care; and provide counseling and health education.

In 1993, HRSA entered into a contract with Mathematica Policy Research, Inc. to conduct cross-site evaluation of the 15 original Healthy Start projects. This national evaluation consists of both a process and outcome analysis. The basic questions to be addressed are: Did the Healthy Start program succeed? If so, why? If not, why not? And what would be required for a similar intervention to succeed in another setting?

The process evaluation of Healthy Start will detail the individual characteristics of the original 15 Healthy Start projects, their health and social service infrastructure, organizational characteristics, and descriptive information about the type and scope of local interventions.

The outcome evaluation entails a quantitative analysis of the overall success of the Healthy Start program through assessments of multiple program outcomes such as infant mortality, low birthweight incidence, and improved maternal and infant health, using client-specific data as well as secondary data sources. The national evaluation is a 5-year effort, with a final report due in 1998. To date, the following national evaluation tasks have been completed:

- Site visits in 1994 and 1996, with telephone follow-ups in 1995,
- Focus groups of providers and consumers at all project sites,
- Postpartum survey of approximately 2,800 women,
- Selection of comparison sites,

- Collection of client level data,
- Meetings of Technical Advisory Group in 1994, 1995, and 1996, to advise on details of the study,
- Compilation of services available in each Healthy Start project site,
- Preparation of first and second year annual reports highlighting the implementation and operational phases of the Healthy Start program, and
- Initial assessments of the sustainability efforts at each project site.

In addition to the national evaluation, the 15 original Healthy Start projects have the administrative option of conducting local evaluations. Each of the Special Projects is required to conduct local evaluation. These evaluations are designed to monitor the implementation of project interventions and/or assess more site-specific intervention strategies. A local Fetal and Infant Mortality Review process is also being conducted utilizing both community and professional committees to provide timely feedback on project interventions.

The Healthy Start Initiative also features an aggressive **national and local public information and education component** that raises awareness of the problem of infant mortality and promotes prenatal care and other healthy behaviors. The highlight is a national public service campaign, developed with the assistance of the Advertising Council. A recently developed set of public service advertisements which will be released this summer urges women to avoid putting their baby's health "on the line" by seeking early and regular prenatal care. The campaign will feature two new toll-free numbers—one for English-speaking callers and one for Spanish-speaking callers. These national prenatal care hotlines will connect callers to the Healthy Start project or State maternal and child health office closest to where they live.

When we look at Healthy Start, we see an Initiative that has been instrumental in reforming systems of care in 22 communities. Those benefiting from Healthy Start services range from women of childbearing age and infants to community members throughout the Nation. Consider the sheer number of people served in 1995 alone:

- 114,000 women of childbearing age received Healthy Start services.
- 18,000 teens participated in school-based health and/or teen pregnancy prevention programs.
- 48,000 adolescents participated in various other risk prevention programs.
- Over 20,000 babies were born to Healthy Start clients.
- 212,000 prenatal care encounters and 85,000 pediatric contacts were provided.
- 32,000 families received transportation assistance to access needed services.
- 16,000 families took advantage of Healthy Start-funded child care services.
- Community outreach activities reached over 188,000 residents.
- Public education and media activities reached over 12 million residents.

As the initial Healthy Start demonstrations conclude, we in HRSA are providing technical assistance to the projects in a number of ways designed to sustain and replicate effective program models to decrease infant mortality, including:

- Assistance in making the Healthy Start program a permanent part of a community's infrastructure. This includes skillfully packaging effective infant mortality reduction strategies and marketing them to managed care providers.
- Assistance in transitioning Healthy Start projects to serve as mentors for States or communities interested in establishing similar infant mortality reduction programs.
- Assistance in developing linkages with corporations, foundations and other business entities, thereby forming enduring public and private sector partnerships.

The support of the private sector has always been a main ingredient of Healthy Start. In 1992, eleven private sector organizations including, among others, March of Dimes, Kiwanis International, The Urban League and the Washington Business Group On Health, formed a Healthy Start Steering Group to provide advice to communities in leveraging the resources of local companies and foundations. Johnson & Johnson chairs the Private Sector Steering Group. The company has not only given tangible assistance in raising public awareness of the tragic problem of infant mortality, but also sponsored a paid advertising campaign with the message "It's never too early to give your baby a Healthy Start." This public service campaign generated nationwide prime time coverage for Healthy Start and helped the local projects reach people in need. Today, Johnson & Johnson is at the forefront of a new private sector effort—to organize a national summit of community and corporate leaders. This summit will allow the Healthy Start program to showcase results and further enhance private sector involvement in the national efforts to reduce infant mortality.

It has taken several years for the Healthy Start projects to identify the unique contributing factors behind the high infant mortality rates in their target populations and to find manageable solutions for their communities. With a national in-

vestment of $460 million, the Healthy Start program has had valuable impact in addressing health, social and economic issues beyond infant mortality reduction. The Healthy Start experience with involving communities in public health programs ought to be used as a learning lab for both urban and rural communities across the country, especially for programs targeting low income and underserved populations. I can say that we have indeed broadened dour knowledge base. It would be a tragedy to our Nation to halt our advances now.

Commencing with FY 1997, we plan to take the lessons learned to date and build on these successful experiences through a two-pronged approach that will maximize the use of financial resources, as well as knowledge and experience. Many of the current projects will be continued with an additional role—that is, these projects will become "teachers", sharing the "how to" of their successes and the "what" and how "not to" from their experiences and knowledge. Their "students" will be other communities and States, suffering from the ravages of high infant mortality and low birthweight infants, desirous of putting in place the mechanisms to address their particular situation. We will call these "teachers" Healthy Start Resource Centers, mentoring to those seeking knowledge, while also continuing their effective strategies within their own communities. The second prong of our approach will be the funding of new communities to operationalize successful models applicable to their respective communities, building coalitions, and the mechanisms for sustainability—eventually themselves becoming Resource Centers. This approach will further expand integration of State/local Title V programs and other existing maternal and child health services. We believe this plan will maximize the efficient use of resources and their impact on infant mortality reduction.

In closing my prepared testimony, I would like to emphasize that Healthy Start is a driving force for empowering individuals and communities to take charge, promoting healthy mothers, infants ad families, building stronger communities, States, and a Nation, to take on tomorrow's challenges, while conserving future resources.

This concludes my testimony. We will be happy to answer any questions you may have.

Senator FAIRCLOTH [presiding]. Thank you, Dr. Sumaya.

Senator Kassebaum left me in charge without a lot of instructions, but as I understand it, Dr. Nora and Dr. McCann do not wish to testify?

Dr. SUMAYA. No. I was presenting the opening statement.

Senator FAIRCLOTH. Senator Kennedy.

Senator KENNEDY. Just very briefly, how does this program interact with these cuts in Medicaid? What is going to be the real impact on these various centers, whether it is up in Boston or in other places where you have these targeted programs? How are we going to be able to evaluate how these programs are doing if we are, on the other hand, seeing reduction in services for children in the Medicaid program? What is going to be the bottom line? Here, we are getting some resources, hopefully—the administration has called for $72 million—but we are seeing very significant reductions in the Medicaid program.

Dr. SUMAYA. I think that is a very good question, Senator Kennedy. I think there would be increased problems as we look to the future with some of the slowdowns we see in Medicaid expansion and the dismantling of some public hospitals that we are seeing ahead as well. We are seeing that managed care activities are expanding but are not embracing a number of the high-risk populations and certainly not the uninsured.

So there are a number of indicators out there that I think will make things much more difficult, yes.

Senator KENNEDY. Thank you, Mr. Chairman.

Senator FAIRCLOTH. Dr. Sumaya, could you describe how you determine which program sites are successful and which are not?

Dr. SUMAYA. There are a number of mechanisms, and I will give an overview and then have Dr. Nora and Dr. McCann address

some more of the detail. We have ongoing evaluations at the local level as well as at the national level. We have an ability right now to present some information on the processes that have been put in place, showing where there has been community infrastructure development, the coalitions in the communities, to improve access to care whether mobile vans are being used, whether there is bilocation of activities and services, but a way to muster the forces to increase access to care and prenatal care.

We also have information currently to show that we have a number of family support systems in place, for example, male spouse programs that are very important and the development of community health workers for outreach. We have good information currently on the vast dissemination that is occurring at the local and national levels, bringing out the public information, the visibility of this problem, and how the communities need to muster their forces together to improve this. And we do have some indications right now through the health programs that there are projects that are improving their low birth weight statistics, projects that are showing reductions in high-risk behavior for a number of the populations.

I will conclude by saying that we have some process information at hand. The hard data, the infant mortality data, is lagging somewhat behind because the final data is not yet available. It lags about 2 years behind the year at which we are looking. So we plan to have specific data at hand on infant mortality within the next few years, showing what is happening, but there is a lag period. And these other indicators that I think are very important show that we are going in the right direction, and that this is a successful project.

Senator FAIRCLOTH. Well, my question is, in a word, have you determined those sites that are unsuccessful?

Dr. SUMAYA. Yes. We have site-by-site information on that, and Dr. Nora may want to make some additional comments on that.

Senator FAIRCLOTH. I want to ask one more question. What do you plan to do with those that are unsuccessful? If the funding is continued for the program—if it is continued—what are you going to do with the sites that have been unsuccessful in reaching the goal?

Dr. SUMAYA. On those sites, I probably would use a different term than "unsuccessful," rather as being "less successful," because there are many extenuating circumstances to the degree of success.

We provide a lot of technical assistance to all of the programs. The ones that seem to be more successful at this point are the ones that, for the future, we would like to continue those successful activities and have those become the resource centers to others that have not been successful and to those communities which do not have a program in place at this point.

Senator FAIRCLOTH. So, in the unsuccessful sites, you would like to do what?

Dr. SUMAYA. We would like to provide additional support, maybe not to the degree of some of our successful ones, but to continue the efforts and pick up on those areas of deficiency and try to improve on those particular areas.

Senator FAIRCLOTH. I have no further questions.

Did you have additional testimony you would like to give?

Dr. SUMAYA. I think I would like Dr. Nora to expand on that.

Senator FAIRCLOTH. Well, we would be glad to hear from her, but I have no question.

Dr. NORA. Thank you, Dr. Sumaya and Senator Faircloth. I think the question is a good one, and we do have technical measures that we track these projects with.

We actually have three projects that are on what we call "exceptional" status because of fiscal matters or program matters. That does not mean that the entire program is not functioning as we would like to see it. There are portions and components that are carrying out our responsibilities. In addition, we do have one project that was on "exceptional" status that we have been able to work with——

Senator FAIRCLOTH. "Exceptional" means that it was not working well?

Dr. NORA. It means that there are fiscal questions and concerns that are not being addressed appropriately, or program concerns. And because these particular projects have fallen into this category, we track them more carefully; we do not allow them to draw down their funds——

Senator FAIRCLOTH. By "fiscal questions," you mean lack of accountability of the money?

Dr. NORA. Financial. That is right.

On the other hand, one project, for example, has been able to overcome those complicating factors and move off of the "exceptional" status.

So we have attempted to provide much outside consultation and technical assistance to all of the projects. As you have pointed out, we do seem to have some that are highly successful, some that are middle-of-the-road, and some that are less so; but we believe that there are components of each of them that have brought about change in the community, and that is critical and important to our endeavors.

Senator FAIRCLOTH. As you might be aware, Dr. Sumaya, I am new on the committee, and this is totally new to me, but what is the total cost of this program per fiscal year?

Dr. SUMAYA. Per fiscal year, it has been at a rising trend and now a slight decline, but it has been just under $500 million that we will be completing over the 5-year period of time, and for fiscal year 1997, we are asking for $75 million to continue the two-pronged approach.

Senator FAIRCLOTH. So it has been running about $100 million per year?

Dr. SUMAYA. Yes, but it has not been the same every year.

Senator FAIRCLOTH. And you are asking for $75 million.

Dr. SUMAYA. For the maintenance in a two-pronged approach for this particular year.

Senator FAIRCLOTH. For the coming year, OK.

Dr. SUMAYA. And one of the main reasons for that, Senator, is that the problem of infant mortality is pervasive throughout this country, and we can easily identify hundreds of other communities that have rates that are 1.5 times the national average. So we feel

that it is extremely important that this program be maintained in the fashion that, hopefully, we can work together and design.

Senator FAIRCLOTH. Well, I was looking at some of the literature here, and I saw that one of the North Carolina counties is close to one of the highest in the Nation, and I was surprised to see that because it is not a poor county. It is Scotland County, and I was surprised to see that.

Dr. SUMAYA. We have Pee Dee in South Carolina.

Senator FAIRCLOTH. Here it is. They have 20.6; Shannon County in South Dakota is the highest, with 28.5, and this North Carolina county, which is actually a very prosperous county, is 20.6. I am surprised. I am not questioning it; I was just surprised to see it.

Dr. SUMAYA. Yes. And I think there are many other counties with similar figures, unfortunately, and that is the point of why we think the continuation of this program is essential.

Senator FAIRCLOTH. But in a word, you have been getting $100 million on average for 5 years.

Dr. SUMAYA. On the average.

Senator FAIRCLOTH. And now the request is for $75 million.

Dr. SUMAYA. Yes, sir.

Senator FAIRCLOTH. All right. Thank you so much for being with us this morning.

Dr. SUMAYA. Thank you.

Senator FAIRCLOTH. Would the next panel come forward, please? Thank you for being with us and for being available for testimony and questions this morning. I am sorry that more of the committee could not be here. As you might well have guessed, the Senate has been in a little bit of a turmoil since yesterday; there has been a lot of activity.

Would each of you, starting with Mr. Coyle, briefly tell us where you are from and what you do?

Mr. COYLE. I am an assistant commissioner in the Baltimore City Health Department for Maternal and Infant Programs, and I am also the Executive Director of Healthy Start.

Ms. STRAWTHER. I am a client of the Baltimore City Healthy Start Program at the Middle East site.

Mr. BANKS. I am a Healthy Start client, and I am also involved in a Lead Abatement Action Project.

Ms JENKINS-SCOTT Good morning. I am Jackie Jenkins-Scott from Boston, MA. I am president of a health and human services agency which is a participant in the Boston Healthy Start program.

Dr. MCCORMICK. I am Dr. Marie McCormick. I am the chair of the Department of Maternal and Child Health at the Harvard School of Public Health, and I am one of the three principal investigators on the national evaluation.

Senator FAIRCLOTH. All right. Mr. Coyle, we will begin with your testimony.

STATEMENTS OF THOMAS P. COYLE, EXECUTIVE DIRECTOR, HEALTHY START, AND ASSISTANT COMMISSIONER, MATERNAL AND INFANT CARE AND SPECIAL PROJECTS, BALTIMORE CITY HEALTH DEPARTMENT, ACCOMPANIED BY DORETHA STRAWTHER AND CHRISTOPHER BANKS, PROGRAM RECIPIENTS AT BALTIMORE CITY SITES; JACKIE JENKINS-SCOTT, PRESIDENT, DIMOCK COMMUNITY HEALTH CENTER, ROXBURY, MA; AND DR. MARIE C. McCORMICK, PROFESSOR AND CHAIR, DEPARTMENT OF MATERNAL AND CHILD HEALTH, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MA

Mr. COYLE. Senator, practiced for the last 10 minutes saying, "Good morning, Madam Chairperson," so I have been thrown off from the start.

Senator FAIRCLOTH. Well, you can skip that.

Mr. COYLE. Thank you for inviting me and two members of our Healthy Start family to testify today. We have already introduced the two clients who are from our Healthy Start program, so I do not need to do that again.

During the last 3 years, we have had many visitors come to see our Baltimore City Healthy Start Program. Invariably, they leave the visit with the real conviction that they have seen a comprehensive, coordinated, community-based program that truly serves the needs of our poorest citizens.

This is not by accident. Our Healthy Start staff work hard at making this program effective. More importantly, however, the reason why so many visitors are impressed with our efforts is due to the foresight and wisdom of the Federal Government. The Department of Health and Human Services has created a program that allows the flexibility to address the needs of families comprehensively and has provided us with the resources to do so.

In the past, infant mortality and low birth weight have been viewed primarily as medical issues. What Healthy Start has demonstrated is that in our poorest inner city neighborhoods, which have the highest incidence of infant mortality in the United States, these problems are not solely medical, but are rooted in a complex set of health, social and economic issues. And in my opinion, the devastating consequences of infant mortality and low birth weight will only be solved through the broad, comprehensive approach that the Healthy Start programs across the country represent. The traditional categorical approach of Federal programs will not get the job done.

Another unique feature of Healthy Start is that it is outcome-driven. This means that we are directly accountable to all of you in this room for actually reducing the incidence of infant mortality in our poorest communities. You heard this earlier, but the Federal Government has established one of the most ambitious goals ever for a new initiative—that is, to reduce infant mortality by 50 percent over a 5-year period. I do not need to tell members of this committee or you, Senator, how ambitious that outcome goal is. Would that other Federal initiatives set similar goals of reducing incidences of child abuse, teen pregnancy, and substance abuse in our major cities.

The really good news is that in Baltimore City, our Healthy Start program, and other Healthy Start programs across the country, are well-positioned to meet this ambitious objective.

Prior to the initiation of Healthy Start in Baltimore, the infant mortality rate in our poorest communities was 20.1, meaning that a little over 20 infants out of 1,000 died before their first birthday. Currently, the infant mortality rate is 13.8, representing a 31 percent reduction. We feel confident that if the Federal Healthy Start program continues, we will reach our goal within the next 2 years.

But there is even better news. The objective of Healthy Start is not only to keep babies alive, it is also to decrease the number of low birth weight and very low birth weight babies, as you heard from Senator Specter a few minutes ago. These are the infants who live, but who may have physical and mental disabilities for a lifetime, with the likelihood of great suffering for themselves and their families.

Also, as you heard from Senator Specter, these low birth weight babies often cost the taxpayer enormous dollars. In Baltimore City, the average Medicaid neonatal hospital care cost for a very low birth weight baby ranges from $30,000 to $200,000. These same infants often require thousands of dollars more in inpatient hospital care during their first year and beyond. The most severely disabled will be institutionalized at long-term pediatric hospitals at the annual cost of $250,000.

The human and economic costs of these preventable poor birth outcomes are enormous, and the costs in the form of medical bills for these tiny infants and costs for special education continue well past infancy.

I am delighted to tell you that the Baltimore City Healthy Start program has recent high-quality data indicating significant reductions in the rate of very low birth weight infants. These data are of high quality and have been confirmed by the staff at the Johns Hopkins School of Hygiene and Public Health.

In Baltimore's highest-risk communities, the very low birth weight rate for pregnant enrolled women served by our comprehensive neighborhood Healthy Start centers is 62 percent lower than the rate for those who did not receive Healthy Start case management and support services during their pregnancy.

Let me finish with two final points.

Senator FAIRCLOTH. Take your time. Do not worry about the light.

Mr. COYLE. First, we have made special efforts in Healthy Start to de-professionalize many of our outreach and home visiting services by hiring residents from the neighborhood to carry out this work. The vast majority of these residents are women who are or were on welfare. We now have over 150 such staff, and we are the largest employer of neighborhood people in one of the communities in Baltimore.

Second, by definition, maternal and child health programs have left out the fathers, with devastating consequences. Healthy Start in Baltimore has created a special fathers' initiative called the men's services program. This program takes the highest-risk dads and transforms them into nurturing parents through an intensive support process and employment.

In short, Healthy Start is a unique and wise investment. I hope it will continue.

Thank you.

Senator FAIRCLOTH. Thank you, Mr. Coyle.

Before we go on, I have just one question. You were speaking about bringing in the fathers and getting them involved, and you said "through an intensive support process and employment." What does "employment" mean? In what context do you mean it there?

Mr. COYLE. We mean it in two ways. We have a job developer who goes around to major corporations, to hotels, to a whole range of places and tries to create jobs for our guys. In addition to that, we were fortunate in my office to get a $12 million grant from HUD to rehab 1,000 houses in Baltimore for lead abatement, and we have used that project as an employment program for the poorest men in our program. After they go through a whole process of changing their behavior—and Chris Banks is one perfect example—many of these men have had drug problems, have been in prison, have been drug dealers—once we have put them through the process, and we feel they are ready, we give them a full physical and a drug screening, and if they can pass that—which often, in the early days, they could not, but now we are getting very many more men who can—we guarantee them a job in the construction field.

Senator FAIRCLOTH. Thank you. Now, Ms. Strawther and Mr. Banks, you were not going to testify, so the next witness is Ms. Scott.

Ms. JENKINS-SCOTT Good morning, Senator Faircloth.

I have submitted extensive written testimony, and in the interest of time, I would like to move over to the section of my testimony that focuses on what we have been doing in Boston.

Boston was ideally suited to receive one of the first Healthy Start grants. Our infant mortality rate was unacceptably high. We had in place an excellent system of care by both community-based organizations and academic medical institutions to attack this problem. We had captured the interest and commitment of Government, business and community leaders, private sector funders, and health and human services providers to work together to see what we could do to alleviate this problem. What we lacked were the resources necessary to keep us focused and to fill in the gaps in service.

On behalf of the hundreds of beneficiaries of the Healthy Start Initiative, I want to thank you for funding this important program.

Let me just briefly describe the Boston Healthy Start Initiative and share with you some of our results over the past 5 years.

The primary goal of the Boston Healthy Start Initiative is to reduce infant death by 50 percent in the project area by the year 1997. This goal is to be achieved by employing three major intervention strategies—first, what we call the empowerment of individuals families and communities; second, enhancement of services, access, and utilization; and finally, building systems and program linkages.

For each of these intervention strategies, we developed a detailed strategic plan which has been carefully followed over the past 3 years and modified as necessary.

First, empowerment of individuals, families and communities. Now, "empowerment" is a word that is often used, but it is also very misunderstood. The Boston Healthy Start Initiative has demonstrated that the Healthy Start goal of real community involvement is possible. From the very beginning of our project, we developed a process which required that community residents participate in all levels of decisionmaking and that the programs that were designed to ameliorate many of the deeply-rooted causes of infant mortality would be designed by these residents.

Our project established a community involvement process which ensured that the diversity of our community was represented on the governing board. By year 4 of our project, we had increased community involvement on the executive committee and in the consortium to 60 percent.

Several important community initiatives had been implemented during the years, including a major initiative to train congregation members of project area churches as health educators and support them in their volunteer activities.

We have created a massive public education component which is really working to increase the awareness of infant mortality as well as the services that are available through this effort.

One of the remarkable benefits of the Boston experience is the evolving relationship between Government, academic medical institutions, community-based organizations and community residents. We have provided an opportunity for all of these players to interact and to learn more about each other, an opportunity that would not have been possible without this Healthy Start Initiative.

Second, enhancement of services, access and utilization. The key question to be answered in order to reduce infant mortality in Boston was, How do we remove the barriers and provide support that will get women to utilize the existing service delivery system?

In Boston, we are fortunate to have available very high-quality basic health services, and these services are pretty much available throughout the city. Access was our problem, and here is where the Healthy Start Initiative was invaluable. Through our Healthy Start Initiative, we have been able to support advocacy and outreach activities that are not and cannot be funded through existing basic primary care services such as the Medicaid program. Examples of support programs include pregnant and parenting support groups, community outreach, transportation and child care, special women's health education, smoking cessation programs, perinatal substance abuse, nutrition, and case management.

Each year, over 2,000 high-risk pregnant women receive services through these activities, and some of them have made remarkable accomplishments. Let me just share a few examples from our own projects.

Last year, our project, Project SWAY, recorded 180 group sessions serving almost 4,500 clients. Over 1,000 individuals were enrolled for care. And directly because of the intervention supported by Healthy Start, 90 percent of these women make or keep prenatal and pediatric appointments. Additionally, we have made a significant impact on smoking during pregnancy. Over 88 percent of the women enrolled in Project SWAY did not smoke during pregnancy.

These are a few of the accomplishments made in service delivery, but what is most important in Boston is that we are seeing a steady improvement in the percentage of women receiving adequate prenatal care and a steady decline in the percentage of children born with low birth weight, infant deaths from mortality, neonatal mortality, and postneonatal mortality.

These accomplishments are significant. For each healthy baby born, we are saving thousands and thousands of dollars in high-cost hospitalizations.

Third, building systems and program linkages. One of the most important accomplishments of the Boston Healthy Start Initiative is the collaboration that has developed between community agencies, health providers and community residents. This is a cornerstone of our project, and we have been able to pull together institutions that have been adversaries in the past and provide them with a comprehensive continuum of care.

Five years ago in Boston, major teaching hospitals would not be working with very small Hispanic agencies to better serve high-risk Latino women. Thanks to our Healthy Start program, this is a common occurrence in Boston now.

It is important to reiterate something that Senator Kennedy understands very well, and that is that Healthy Start's effectiveness is very much linked to the ongoing delivery of basic health care services. The advocacy services supported by Healthy Start and the primary care funded by Medicaid go hand-in-hand. One is not effective without the other.

Now, there are many efforts in Congress to reduce Medicaid in ways that will harm children and families. Such efforts include allowing States to use Federal Medicaid dollars to pay for other nonmedical purposes, repeal of the Vaccines for Children program which provides free vaccines to our most needy and vulnerable families, and allowing States to withdraw large amounts of their own funds from Medicaid, forcing further cutbacks in health services.

All of these proposals, if approved, will reduce the effectiveness of the Healthy Start Initiative and, we believe, will very quickly reverse the improvements we have made in infant mortality.

Let me close—and I know I am out of time—by very quickly telling you about a patient.

Senator FAIRCLOTH. That is all right. We are not rushing you.

Ms. JENKINS-SCOTT Thank you. I want to share with you the story of a patient who came to Dimock. Kari is a 27-year-old African American woman who lives in a housing development directly adjacent to our organization. For 8 years, she had been addicted to crack cocaine, and her first child was born while she was using cocaine.

Two years ago, Kari came to Dimock, 3 months pregnant, and joined our prenatal program. She came to Dimock through our Healthy Start outreach activities. We were able to coordinate an intensive program for Kari which was based on our one-stop shopping model of care.

She was detoxed in our specialized inpatient program. She was then enrolled in our day treatment program for pregnant women.

Then, she was able to deliver her child drug-free, and she has been drug-free for the past 2 years.

On June 7th, Kari will graduate from Roxbury Community College and will marry a clean, sober and employed African American community resident. I might also add that Kari developed a healthy, 8-pound, drug-free baby girl, and she and her children are thriving.

Our Healthy Start program was able to provide the supports that allowed Kari to remain drug-free and to make good choices in her life. These are the kinds of results that I know you, Senator, would be very pleased to hear about.

Finally, I strongly urge authorization of the Healthy Start program so that we can continue to reduce infant mortality and improve the lives of thousands of Americans throughout this Nation.

And if I could say one final word, Senator, I would also urge you to remember the critical link between the advocacy and outreach offered by Healthy Start and the absolutely essential direct health care services funded by programs like Medicaid.

Thank you very much.

Senator FAIRCLOTH. Thank you, Ms. Scott.

[The prepared statement of Ms. Jenkins-Scott follows:]

PREPARED STATEMENT OF JACKIE JENKINS-SCOTT, PRESIDENT, DIMOCK COMMUNITY HEALTH CENTER

Good Morning, Senator Kassebaum, Senator Kennedy and other members of the Senate Labor and Human Resources Committee. I am Jackie Jenkins-Scott, President of Dimock Community Health Center. Since its inception, Dimock has been actively involved in the development and implementation of Boston's Healthy Start Program. I am pleased to have the opportunity to share with you some of the highlights and accomplishments of this important program.

Dimock Community Health Center is a comprehensive health and humans services organization serving over 30,000 individuals and families annually from urban neighborhoods throughout the City of Boston and beyond. Our historic nine acre campus in the heart of Roxbury is an ideal setting for our one-stop shopping model of health care delivery. Children, young families, elderly residents, teenagers, and individuals from every walk of life are supported by 40 different programs offered through five clusters: Primary Health Care, Career Development Services, Child and Family Development Services, HIV Services, and Substance Abuse Treatment Services.

For the past four years, we have received $168,451 annually from Boston's Healthy Start Program. These funds support two specialized programs—each designed with a parallel mission—to server high risk pregnant and parenting women. Project SWAY (Street Workers and You), our outreach program for substance abusing women who are pregnant or of child bearing age, provides intensive on-campus follow-up for women who have received care in our residential drug and alcohol detoxification program. Project SWAY also uses street outreach workers who bring active substance abusing women onto Dimock for drug treatment and medical services. Our Women's Health Education Project is designed to follow very high risk women enrolled in Health Services, also with a focus on substance abusers, during pre-natal and post partum periods. Staff provide intense education so that these women will deliver a healthy baby reduce low birth weight and infant mortality. Dimock's outreach efforts have had very successful results which I will highlight later in this testimony.

As each of you know, infant mortality is one of the very important indicators of the health of a community. The problems of persistent poverty, unemployment, violence, hunger, lack of access to health and human services, and racism are a few of the social indicators that underlie the patterns of infant death in Boston and other cities. An attack on these deeply rooted societal problems must be at the heart of any attempt to reduce infant mortality rates.

The horrifying impact of the Nation's infant mortality problem was painfully evident in Boston throughout the 1980s. During this period, Boston the Mecca of mod-

ern medicine, the source of many medical breakthroughs, the home to three of the finest medical schools in the country, an outstanding system of primary care services delivered through a network of 26 Community health centers, and 16 community and teaching hospitals, was also the home of one of the highest infant mortality rates in the United States. Even more dramatic, African American women experienced infant deaths at a rate more than three times that of white women. In fact, the infant mortality rates in some Boston census tracks were higher than that of many third world countries.

Since the mid 1980s a variety of efforts were undertaken in Boston to address the growing infant mortality disparity. Programs were established, however, they were not focused, coordinated or effective. In 1990, the Boston Globe published an important and extensive series on the infant mortality problem which resulted in infant mortality summit which was attended by leaders from the teaching hospitals, community based provides, health care advocates, and public and private funders. It was the first time that such a large and diverse group came together to singularly address this problem. One of the important (strategies) identified was the need for a coordinated effort to ensure greater access to existing primary care and related health services and the need for additional support services to compliment these services. The Maternal Health Commission was established to oversee the coordination of these efforts.

Shortly, after the establishment of the Maternal Health Commission, Congress wisely funded the Healthy Start Initiative and the Health Resource Service Administration (HRSA) issued the Guidance for the Healthy Start Program in May 1991, which provided the rational and template for Boston's grant. This first guidance required that the successful applicant demonstrate that:

- Community residents be involved with the planning, decision making, and solutions that come out of the Healthy Start effort.
- That projects be built on the principles of innovation, community commitment, and involvement, increased access, service integration, and personal responsibility.
- That sites utilize a community based, family centered, and culturally competent approach that will strengthen maternal and infant care system.
- That a consortium represented by all of the major stakeholders provide local participation, oversight, and advise to the grantee agency. This consortium would participate in all decisions regarding the allocation and management of project resources.

Boston was ideally suited to receive one of the first Healthy Start Grants. Our infant mortality rates were unacceptably high, we had in place an excellent system of care by both community based and academic medical institutions to comprehensively attack this problem, we had captured the interest and commitment of government, business and community leaders, private sector funders, and health and human services providers to work collaborative to alleviate the problem. What we lacked were the resources necessary to "keep us focused" and to fill in the gaps in service.

On behalf of the hundreds of beneficiaries of the Healthy Start Initiative, I want to thank you for funding this important program. Let me briefly describe the Boston Healthy Start Initiative and share with you the results of our efforts during the past 5 years.

The Boston Healthy Start Initiative

The primary goal of the Boston Healthy Start Initiative is to reduce infant death by 50 percent in the Project area by 1997. This goal is to be achieved by employing three major intervention strategies:

1. Empowerment of individuals, families and communities;
2. Enhancement of services, access and utilization;
3. Building systems and program linkages.

For each of these intervention strategies, we developed a detailed strategic plan which has been carefully followed and modified during the past 5 years.

1. Empowerment of individuals, families and communities.

Empowerment is an often used, but misunderstood, word. The Boston Healthy Start Initiative has demonstrated that the Healthy Start goal of "real" community involvement is possible. From the very beginning the project developed a process which required that community residents participate in the decision making process and that programs and services would be designed to ameliorate many of the deeply rooted causes of infant mortality. Our project established a community involvement process which ensures that the diversity of our community is represented in the governing board. By year 4 the project had increased the involvement of community residents on the executive committee and in the consortium to 60 percent. Several important community initiatives have been implemented during the years including a major initiative to train congregation members of project area churches as health

educators and support them in volunteer activities in their communities. A public education and information component designed to increase awareness of the infant mortality problem and knowledge of the services available to project area residents.

One of the remarkable benefits of the Boston experience is the evolving relationship between government, academic medical institutions, community based organizations and community residents. This project has provided an opportunity for interaction and learning about each other that would not have been possible with the focused support of this initiative.

2. Enhancement of services, access and utilization

The key question to be answered in order to reduce infant mortality in Boston was, "How do we remove barriers and provide support that will get women to utilize the existing service delivery system?" In Boston, we are fortunate to have available high quality basic health services throughout the city. Access was our problem. Here's where Healthy Start was invaluable. Through our Healthy Start Initiative, we have been able to support advocacy and outreach activities that are not and cannot be funded though existing programs such as basic primary care under the Medicaid program. Examples of support programs include pregnant and parenting support groups, community outreach, transportation and child care, special women's health education, smoking cessation programs, perinatal substance abuse, nutritional support serves, and case management and follow-up services. Each year over 2,000 high risk clients receive services through these actives, about one-half of them are pregnant women. These have made some remarkable accomplishments. Let me share a few examples from Dimock's own Project SWAY.

During the last year, 180 group sessions were recorded better than 4,500 client contacts. Nearly 1,000 individuals were enrolled for care. Directly because of the interventions supported by Healthy Start 90 percent of these women make and or keep prenatal and pediatric appointments. Additionally, we have made a significant impact on smoking during pregnancy, over 88 percent of women enrolled in SWAY did not smoke during pregnancy.

These are only a few of the accomplishments made in service delivery. Most importantly, we are seeing a steady improvement in the percentages of women receiving adequate prenatal care and a steady decline in the percentage of children born with low birth weight, infant deaths from mortality, neonatal mortality, and post neonatal mortality.

These accomplishments are significant. For each healthy baby born we are saving hundreds of thousands of dollars in high-cost hospitalizations. We know based on history, that without Healthy Start we will again see an increase in all of these indicators.

3. Building systems and program linkages

One of the most important accomplishments of Boston's Healthy Start initiative is the collaboration that has developed between community agencies, health providers, and community residents. This is a cornerstone of Boston's Healthy Start Program. We have been able to pull together institutions that have been adversaries in the past to provide a comprehensive continuum of care. Five years ago, who would believe that a major teaching hospital would work closely with a small Hispanic agency to better serve high-risk Latino women. Thanks to Healthy Start, this is a common occurrence and this is what makes Boston's Healthy Start Program unique and successful. Through these efforts much progress has been made in decreasing barriers to access, simplifying the eligibility and intake process that makes it easier for clients to receive care, reducing duplication of services, and enhancing the continuum of care available to Boston's most vulnerable residents.

It is important to reiterate something that Senator Kennedy understands very well, Healthy Start's effectiveness is inextricability linked to the ongoing delivery of basic health care services. The advocacy services supported by Healthy Start and the primary care funded by Medicaid to hand in hand. One is not effective without the other. There are many efforts in Congress to reduce Medicaid in ways that will harm children and families. Such efforts include allowing states to use federal Medicaid dollars to pay for nonmedical purposes, repeal of the vaccines for children program which provides free vaccines to our most needy and vulnerable families, and allowing states to withdraw large amounts of their own funds from Medicaid, forcing further cutbacks in health services. All of these proposals, if approved, will reduce the effectiveness of the Healthy Start Initiative and will very quickly reverse the improving trends in Infant Mortality. I guarantee we will see large increases in hospitalizations and medical costs. I urge you—do not let this happen.

Let me close by putting a face on this discussion:

Kari (her name changed to preserve confidentially) a 27-year old African American women who lives in Academy Homes, a housing development adjacent to Dimock, had been addicted to crack cocaine for eight years. Her eight-year old son

was born while Kari was actively using cocaine. Two years ago, Kari came to Dimock's pre-natal program three months pregnant and actively using cocaine. Our Healthy Start Women's Health Project coordinated an intense service plan for Kari based on Dimock's one stop shopping model of care. Kari was detoxed in our in our specialized inpatient program, Project New Life. Kari then joined our Day Treatment Program for Pregnant Women. She has now been drug free for two years. On June 7, Kari will graduate from Roxbury Community College and will marry a clean, sober and employed African American community resident. I might also add that Kari delivered a healthy eight pound, drug free baby girl. She and her children are thriving. With Healthy Start funding, Dimock was able to provide Kari with the intensive support necessary for her to stay in treatment, remain drug free, and to make good choices. The result of which we can all be proud, is a productive, healthy lifestyle.

Finally, I strongly urge authorization of the Healthy Start Program so that we can continue to reduce infant mortality and improve the lives of thousands of Americans throughout this Nation. And if I could say one final thing, I would also urge you to remember the critical link between the advocacy and outreach offered by Healthy Start, and the absolutely essential direct health services funded by programs like Medicaid.

Thank you, and I will be happy to answer any questions that you might have.

Senator FAIRCLOTH. Dr. McCormick.

Dr. MCCORMICK. Good morning. As I mentioned earlier, I am one of the senior scientists providing leadership to the national evaluation of the Healthy Start Initiative. What I would like to do this morning is provide an overview of the evaluation strategy and then indicate where we are in the process.

The national evaluation, conducted under the leadership of Mathematic Policy Research, is designed to document both the implementation of the Healthy Start Initiative as well as the impact of the program at each site on infant mortality and its correlates of low birth weight.

The first component of this evaluation is called the process evaluation and documents the particular strategies used by each site to address its infant mortality problem in terms of the organizational and financial arrangements, the deployment of providers of various types, and the services provided.

From the program perspective, that is, what the program thinks it is doing, the information will be ascertained through site visits and telephone interviews with project staff and other program participants. We will also analyze the management information system at each site, review the annual continuation applications and have focus groups with the providers.

But we are also interested in how consumers see the program and what services they have received. We obtain that information from focus groups of clients, a survey of women who are 6 months postpartum at each site with samples of Healthy Start participants and women who did not participate in Healthy Start; and we will also look at the receipt of prenatal care in the vital statistics data.

The second component, the outcome analysis, addresses the effect of the initiative on infant mortality. This component rests primarily on an analysis of vital statistics data for births to women residents in each site and two carefully-selected comparison areas for each program site. This comparison will examine changes in infant mortality and related outcomes in the 5-year period before the program started and during the demonstration period.

As has been noted before, this component of the evaluation is dependent on the availability of files that link infant death certificates to the corresponding birth certificates so that the analysis can

incorporate the extensive information on birth certificates, like characteristics of the parents, age and education, and characteristics of the infant like birth weight. This process of linkages takes at least 2 to 3 years following the last birth in a given calendar year, and this is the reason for the lag that was noted before in the outcomes data.

To date, we have completed three of the four proposed rounds of interviews with project staff, all of the focus groups, and the review of continuation applications up to year 5. The survey of postpartum women was completed last month and will be analyzed this summer. Vital statistics data for the pre-initiative period has been obtained for all sites, and preliminary comparison sites have been identified, with final selection pending review and information from site personnel. Management information system data have also been reviewed for all sites, and feedback has bee provided to maximize the quality and quantity for the year 05 data when the sties are fully operational.

Because of the lag in obtaining relevant vital statistics data, we are therefore unable to describe the effect of the program on infant mortality. While provisional data for 1993 and 1994 are available on an aggregate basis and being analyzed by some sites, at this juncture, we feel that it is imprudent to make definitive statements about impact, especially since some of the sites were not fully implemented at that time.

We are, however, summarizing the data on program implementation which is an important product of such demonstration efforts to gain insights for future public health initiatives based in the community.

For example, we know that somewhere between three and five sites experienced substantial difficulty in implementing their programs, and we are identifying the factors that precluded more effective implementation.

While all programs have similar elements, some very specific models are emerging, and you have heard two of them here that represent almost extremes. For example, the Baltimore program which we have just heard about represents an example of very tightly focused and concentrated effort. In contrast, Boston and Philadelphia have embraced a diffuse approach based on services provided through a broad array of community providers. Some sites like Cleveland and New Orleans have focused on providing services in the neighborhood and employment of community residents through carefully constructed outreach/case management programs. And other sites like Chicago and Oakland have developed family support centers where clinical and case management services are provided in conjunction with other activities like child care during visits, WIC certification, English as second language, and graduate equivalence diploma classes, health education, and other services under one roof.

In summary, the evaluation will provide a rich description of the implementation of the initiative and will attempt to link the implementation of program models to infant outcomes to provide guidance for future efforts to reduce infant mortality.

Thank you.

Senator FAIRCLOTH. Thank you, Dr. McCormick.

Now, I see that we have written testimony of Ms. Strawther and Mr. Banks. Did you want to give the testimony orally, or would you like for us to just enter it into the record?

Ms. STRAWTHER. Give it.

Mr. BANKS. Yes.

Senator FAIRCLOTH. Then, you may go right ahead.

Ms. STRAWTHER. Good morning, Senator Faircloth and members of the committee. I would like to thank you for inviting me here this morning, because where I come from, this is just really unheard of, and it is truly an honor.

I am here to tell a story this morning, a heartfelt story, that I thought I would never be able to tell. Eighteen months ago, I was living in a poor community in East Baltimore, pregnant with my third child, with no husband, no job, and no future. Out of desperation, I called the Baltimore City Healthy Start and gave them my story. That day, a Healthy Start advocate came to my home, and since that day, my life has changed dramatically.

I want you all to know that it was not easy. When I arrived at Healthy Start, I was rebellious and skeptical because I just could not understand how they could help me with my pregnancy or my other two children. It took a while, but after working with my advocate and attending support groups at the center, I realized that Healthy Start was the real deal.

For the first time in my life, I was encouraged to open up and express my feelings and to see that there were other women just like me. Healthy Start made sure that I kept all of my prenatal appointments, and this was absolutely necessary because I carried gestational diabetes with my last baby, and I had to see my doctor three times a week. Not only did they ensure that I kept these appointments, but they accompanied me to the clinic.

I am happy to let you all know that I delivered a very healthy baby boy who is now 7 months old. Also, the really nice part about this is that my advocate was the first person to visit me and the baby in the hospital.

Healthy Start does not stop when the baby is born and leaves the hospital. The program just begins. Healthy Start teaches mothers such as myself how to be good parents and good nurturers. The advocate comes to your house to see how you and the baby are doing and encourages you to go to the center to decide what you are going to do with the rest of your life.

Healthy Start also places great importance on self-sufficiency and independence. The staff work with each woman to determine her career goals, and they emphasize the importance of family planning in meeting these goals. Once a woman has decided about family planning, the Healthy Start staff works with the mother to decide whether she wants to return to school or to seek employment.

I am happy to tell all of you that I have now been hired by Healthy Start to become a neighborhood health advocate. So I will now have the opportunity to help other women who are now where I once was.

I cannot wait to start my new job. I am really excited about it. I hope you will decide to continue this wonderful program.

Thank you.

Senator FAIRCLOTH. Thank you for your testimony, and I must say it is a moving story.

Mr. Banks, did you want to give your testimony?

Mr. BANKS. Yes.

Senator FAIRCLOTH. All right.

Mr. BANKS. Good morning, everyone. I would also like to thank you for the opportunity to speak today.

My name is Christopher Banks. I am 23 years old, the father of two boys and a resident of the Sandtown-Winchester community, which is one of the poorest communities in Baltimore.

Before I tell you about what Healthy Start is doing, let me first tell you about the problems that we face in our neighborhood daily. In my neighborhood and many inner city neighborhoods, there is a high poverty rate coupled with poor education, along with a devastating drug situation. I am talking about both the widespread drug use and distribution of drugs. This in turn leads to escalating crime throughout my community.

These circumstances have taken their toll on the children by making it difficult for the fathers of these children to fulfill their parenting role and responsibility.

Sometimes it seems like we have more drug dealers than working people. I am here to tell you that until we have many more working people than drug dealers, our community will never change for the better.

Our fathers in Sandtown need a better quality of life, they need respect, and they need jobs. And they cannot get any of these things until they have a job first; and most importantly, they cannot take care of their children.

But jobs are hard to come by in Sandtown and Baltimore City, especially when you have little education and little work history—or no work history—and especially when you have been a drug user for many years.

Now let me get back to the men's services program of Healthy Start. Until men's services came along, men in our community had nowhere to go and no resources to help them. Now they do. The way it works is that once the mother is in the program, the staff of Healthy Start seek out the father; the father is enrolled in men's services and given support and counseling on how to be a good parent and what he is going to do with the rest of his life.

What I have seen and what we have found is that most of the men in my community want to do the right thing, but have never been given any real support and guidance. Healthy Start does this. It not only supports the men, but it also demands that they take responsibility for their children and themselves.

Some of the requirements are as follows: They must attend at least one prenatal visit with the mother and two pediatric visits with the child—although they are encouraged to attend them all. They must come to two support groups each week. They must demonstrate that they are more involved with their children. And finally, in order to be considered for employment, they must be drug-free. They are required to take a full physical and a drug test. If they meet all of these requirements, the icing on the cake is that these guys are offered real jobs and real opportunity.

So I hope that you can help us keep this program going—and I would just like to add one more word if I can.

Senator FAIRCLOTH. All right.

Mr. BANKS. I can personally testify to that because now, I am in the lead abatement project—I think most of us know about lead paint and how it affects children. I am in an employment program that allows me to work, offers me health insurance benefits, at least partial, and allows me to de-lead these houses, clean them up and fix them up so that the children can live in them. So I can go to work every day knowing that I am doing something not just for my children but for the rest of the children in the community. And I just hope that I can continue to do that.

Senator FAIRCLOTH. All right. Thank you for your testimony.

I thank all of you for coming. Does anybody else have a statement to make or anything to add? [No response.]

[Additional material submitted for the record follows:]

MARCH OF DIMES
BIRTH DEFECTS FOUNDATION,
NATIONAL GOVERNMENT AFFAIRS OFFICE,
1901 L Street, N.W., Suite 260,
Washington, DC, May 29, 1996.

The Honorable NANCY KASSEBAUM,
Chairman, Labor and Human Resources Committee
SD-428 Dirksen Senate Office Building,
Washington, DC.

DEAR MADAM CHAIRMAN: On behalf of the March of Dimes, I would like to thank you for the opportunity to submit written testimony for the record of the "Oversight Hearing—The Healthy Start Demonstration Project" on May 16, 1996.

The March of Dimes strongly supports the continuation of the Healthy Start Infant Mortality Reduction Initiative. The mission of the March of Dimes is to improve the health of infants by preventing birth defects and infant mortality. We recognize the Healthy Start Initiative as a key national program to apply and evaluate community-based strategies for reducing local infant mortality rates.

Senator Specter has indicated his intention to introduce legislation to authorize the Healthy Start Initiative for five years. While we have not seen the details of this plan, we urge your committee to consider this legislation. We believe Healthy Start has been successful and deserves to be continued in some form. Please let me know if we can be of assistance to your committee and its staff as you consider the future of the Healthy Start Initiative. Thank you for your leadership in this important area.

Sincerely,

KAY JOHNSON, *Director*
Policy and Government Affairs

PREPARED STATEMENT OF THE MARCH OF DIMES BIRTH DEFECTS FOUNDATION

The March of Dimes Birth Defects Foundation strongly supports the continuation of the Healthy Start Infant Mortality Reduction Initiative. The mission of the March of Dimes is to improve the health of babies by preventing birth defects and infant mortality. We recognize the Healthy Start Initiative as a key national program to apply and evaluate comprehensive community-based strategies for reducing local infant morality rates. The program has received bi-partisan support from both the Bush and Clinton administrations and we urge the Congress to support its continuation in fiscal year 1997.

March of Dimes Involvement with Healthy Start

The March of Dimes has had a special interest in this initiative since it was first announced by Department of Health and Human Services Secretary Louis Sullivan at a national March of Dimes meeting in January 1991. Over the past five years, March of Dimes staff and volunteers have worked continuously to enhance the quality and focus the direction of the program, as well as to ensure its annual funding. Specific examples of early efforts include: providing comments on the initial federal guidance; documentation of the need for projects in rural communities; participation in the grant review; and participation in development of the evaluation. In addition,

fulfilling our commitment to public-private partnership, our Foundation has invested approximately $1 million in direct and in-kind support for the 22 Healthy Start sites. Staff and volunteers from local March of Dimes chapters have been involved with Healthy Start sites in a variety of ways. March of Dimes chapter support includes health education materials, technical assistance, participation in local consortia, and advocacy. And just as we were involved in the launching of this initiative, we are eager to play a role in its future.

Background

The Healthy Start Initiative is a demonstration program to test community-based strategies for infant mortality reduction, with the ambitious goal of reducing infant mortality by 50 percent and improving maternal and infant health over 5 years in selected communities with high infant mortality rates.

Originally 15 sites, 13 urban and 2 rural, were selected to receive federal funding. Six additional sites were approved but unfunded. March of Dimes provided funding to these sites: to support the continuation of the consortia; fund a small, high priority infant mortality reduction activity; and assist communities in leveraging additional public and private funds. Seven additional Healthy Start Special Projects were funded by the Federal Government at the end of FY 1994, bringing the current number of Healthy Start sites to 22. (The Special Projects include four of the March of Dimes funded sites.)

Local programs are built on the principles of innovation, community involvement, access, service integration, and personal responsibility. In each community, a comprehensive plan was completed and approved prior to implementation of the project in October 1992. Each site has a Healthy Start Consortium, reflecting a partnership of consumers, providers, and community-based organizations and groups, to set priorities and oversee the project. This consortium identified the unique mixture of factors contributing to their high infant mortality rate and planned interventions that respond to and reflect community needs and resources.

Project activities include: better integration of services, enhancing utilization of Medicaid, WIC and substance abuse treatment programs, increasing access to prenatal and other primary care, expansion of job training and social supports, and prevention of substance abuse and teen pregnancy. Each site has an infant mortality review study designed to identify preventable infant deaths in the community (and based on a national model developed through the American College of Obstetricians and Gynecologists and funded in part by the March of Dimes and Robert Wood Johnson Foundations). At the national and local level, funds also are used for media campaigns and evaluation to measure the impact of this demonstration project.

Impact of Healthy Start

Because the Healthy Start Initiative is a demonstration project, an important component of the project is an evaluation study. The Department of Health and Human Services is overseeing a national evaluation to analyze whether the program has brought about changes in the following health measures: infant mortality; infant health status; pregnancy outcomes; women's health status during the perinatal period; health status and social conditions of women of child-bearing age and their families; ad other factors associated with infant mortality.

The evaluation will examine how changes in these outcomes are linked to specific innovative intervention strategies developed by communities. The goal is to be able to identify a broad range of community-driven strategies and interventions which significantly reduced infant mortality, and then these successful interventions can be replicated in other communities.

While the final evaluation report is not due until 1998, we have some early indicators of success. The most notable accomplishment is infant mortality reduction. While national data are not available yet, some local data have been provided by Healthy Start sites and reported by the Health Resources Services Administration. Preliminary and provisional vital statistics from 1994 indicate a decrease in infant mortality and low birthweight in targeted project areas, especially among clients participating in project services. Fourteen of the original sites show real improvement in infant morality rates for project areas. Other examples of success include:

- public-private sector partnerships, both locally and nationally, have been created;
- service coordination—many sites have "one-stop shopping" with co-location of services;
- community participation has been increased, from employing indigenous community workers to developing local advisory boards;
- expanded perinatal services—including prenatal care, wrap-around services, adolescent health and prevention services;

• enhanced community-based structures—including integrated service delivery systems, functional consortia, infant mortality reviews, and new management information systems.

Recommendations for Fiscal Year 1997 and Beyond

The President's Fiscal Year 1997 budget for the Department of Health and Human Services includes a request for $74.8 million for Healthy Start. The justification for the Appropriations Committees indicated this funding would "provide the opportunity to replicate the best models from the demonstration phase of the Initiative ad share lessons learned with over 300 urban and rural communities with a high rate of infant mortality." The funds would be used to continue some of the current projects as resource centers and to fund new projects to replicate successful strategies.

Senator Specter has indicated he will introduce legislation to authorize the program for the next five years and he suggests funding of at least $100 million. While Senator Specter's bill has not yet been introduced, the March of Dimes has supported adding structure in statute to this program. Structured authority helps to direct funds and helps protect a program during transitions of administration. We understand that Senator Specter will call for a gradual reduction in federal funds and an increase in private funding. This plan for eventual self-sufficiency makes sense.

Healthy Start has enjoyed bi-partisan support. The Bush administration launched the demonstration project and the Clinton administration has proposed continuing it beyond the initial five years.

Conclusion

Reducing the Nation's tragically high rate of infant mortality requires collective action on the part of the government, the private sector, and the nonprofit community. Healthy Start has played a key role in this effort by bringing together these groups and testing strategies for integrated services, and improved access to health care and other supports needed to improve infant health and survival. We believe the Healthy Start program has made progress and it will be successful. It would be a tragedy to end this valuable program now, before it reaches its full potential, and before the lessons learned can shared with other communities. We urge you to authorize and fund the program for five more years. Thank you.

Senator FAIRCLOTH. If not, the hearing is adjourned. I thank you.

[Whereupon, at 11:20 a.m., the committee was adjourned.]

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